

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1342

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County Hagerstown
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Penn County Franklin
 City or town Mercersburg Pa
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R D 10
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME William E. Alter

3. (b) Social Security Number
203-10-2981

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Grace Alter
 7. Birth date of deceased (mo., day, yr.) Feb. 17 - 1910
 8. AGE: Years 36 Months — Days 6 If less than one day
 hrs. min.

9. Birthplace Nesh Run Pa Franklin Co
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Edwin Alters
 13. Birthplace Greensburg Pa.
 MOTHER 14. Maiden name Mary B. Stokes
 15. Birthplace Nesh Run Pa.

16. Informant Lee M. Alter
 Address 19 N. Jefferson St. Greensburg, Pa.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 26 - 46
 (month) (day) (year)

Cemetery or crematory Myers County Burial Pa R
 Location The Lininger

18. Funeral director Mercersburg Pa.
 Address

19. Feb. 24 46 Black Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 19 46 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb 17 19 46 to Feb 23 19 46
 and that I last saw him alive on Feb 23 19 46

Immediate cause of death Uremia

Due to Infected pyelonephrosis
creators

Due to Calculi bladder
due to congenital stenosis
 Other conditions ureteric meatus

(Include pregnancy within 8 months of death)

Major findings of operations above Date of op.

Autopsy results above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. L. Houghton M.D.
 Address Hagerstown Md Date signed Feb 23 46

RECEIVED
FEB 26 1946
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33a

CERTIFICATE OF DEATH

Reg. Dist. No. 01921 301

1. PLACE OF DEATH:

County Washington CountyCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 yrs.

Hospital, institution, or street address where death occurred:

Artizan St. 139 N.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Artizon St. 139 N.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Mr. William Harvey Babylon

3. (b) Social Security Number

216-092-151

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Rhoda M. Bablon6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) Oct. 1 18758. AGE: Years Months Days If less than one day
70 5 7hrs.min.9. Birthplace Kokoma Ind.
(Town, county, and state)10. Usual occupation Carpenter & Insurance11. Industry or business Carpenter & Insurance Agent12. Name Emmanuel Babylon13. Birthplace Westminister Md.14. Maiden name Caroline B. Powell15. Birthplace Westminister, Md.16. Informant Rhoda BabylonAddress Williamsport, Md.17. Burial Date thereof Feb. 10 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory United Brethern ChurchLocation Tharmont Md.18. Funeral director Edith V LeafAddress Williamsport, Md.19. Feb 10 1946 Mrs E Lee McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1946 at 10⁰⁰ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 7 1946, to Feb 7 1946and that I last saw him alive on Feb. 7 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

6 daysDue to Arterio sclerosis1 1/4 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

William M. D. or other 2/5/46
Address Williamsport Md. Date signed

RECEIVED

FEB 12 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01922 23

Reg. Dist. No. 306

1. PLACE OF DEATH:

County WashingtonCity or town Near Hendersonville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 yearsHospital, institution, or street address where death occurred: —How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Near Roundville Md
(If outside city or town limits, write RURAL and give nearest town)Street No. none
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Joseph. H. Bachtell

3. (b) Social Security Number

3903

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

8.(b) Name of husband or wife

none7. Birth date of 1-1-1906
deceased (mo., day, yr.)6.(c) If alive, give age — years

8. AGE:

Years

40

Months

6

Days

15

If less than one day

— hrs. — min.

9. Birthplace

Chewsville Md. Co. and
(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

FATHER

12. Name

Reynolds. H. Bachtell

13. Birthplace

Chewsville Md

14. Maiden name

Fannie. Longrecher

15. Birthplace

Chewsville Md

16. Informant

Mrs. Albert. Patton

Address

Chewsville Md

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Chewsville Cemetery

Location

Chewsville Md

18. Funeral director

Geo. B. Hoover

Address

Smithsburg Md

19.

Date rec'd by registrar

Feb 17th 1946Geo. W. Ferguson
Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1946 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 14 1946 at 1 P M and that I last saw him alive on Feb 14 1946

Immediate cause of death

Heart failure from overwork 20 mts

Due to

hypertension 4 mts

Due to

hypertension 4 mts

Other conditions

—

(Include pregnancy within 3 months of death)

Major findings of operations

—

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur?

(City or town)

(County)

(State)

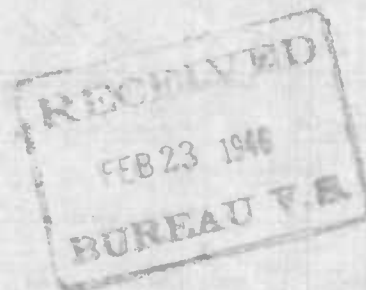
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. G. H. of Smithsburg 2/16/46
M. D. or other 2/16/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Yeager

01923

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 Years
 Hospital, institution, or street address where death occurred:
925 Concord St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 925 Concord St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3.(a) FULL NAME

William Alford Baker

3.(b) Social Security Number

214-09-0737

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Florence Y.
 6.(c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) October 4 1883
 8. AGE: Years 62 Months 4 Days 15 It less than one day hrs. min.

9. Birthplace Union Bridge Carroll Co. Md.
 (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Pangborn Corp.

12. Name David Baker

13. Birthplace Westminster Md.

14. Maiden name Anna Arnold

15. Birthplace Warfieldsburg Md.

18. Informant Mrs. Florence Y. Baker

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 2/21/46
 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 20. 19 46 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 19 46 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16. 19 46 to Feb. 19. 19 46
 and that I last saw him alive on Feb. 19. 19 46

Immediate cause of death Coronary Occlusion DURATION 3 days
(Dilated Hypertrophied Heart) 3 days
 Due to Acute Pericarditis 3 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Howard Yeager M. D. or _____

Address Hagerstown Md. Date signed Feb. 20, 1946

RECEIVED

FEB 22 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 years
Hospital, institution, or street address where death occurred
Washington County Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 965 Mulberry Ave.
(If rural, give LOCATION)
None
2.(a) If veteran, name war

3. (a) FULL NAME

David Luther Beckley

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Mary Josephine Beckley
7. Birth date of deceased (mo., day, yr.) January 8 1872 6.(c) If alive, give age years
8. AGE: Years 74 Months 1 Days 2 If less than one day hrs. min.

9. Birthplace Halfway Washington Md.
(Town, county, and state)
None

10. Usual occupation

11. Industry or business None

12. Name David Beckley

13. Birthplace Near Hagerstown Md.

14. Maiden name Margaret A. Watkins

15. Birthplace Halfway Md.

16. Informant Mrs. Edward Summers

Address Hagerstown Md.

17. Burial Date thereof Feb. 13, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. Feb 12. 46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 46 at 8:30a M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/7 1946 to 2/10 46

and that I last saw him alive on 2/9 46

Immediate cause of death Congestive cardiac failure DURATION Unknown

Due to Atherosclerotic Heart Disease & muscular fibrillation Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Horn Co. Sec. to D.

Address 154 W. Washington St. Hagerstown Md. 2/11/46

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 15 1946
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

01925 23

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
 City or town Smithsburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 1/2 yrs.
 Hospital, institution, or street address where death occurred: -
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Smithsburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Susan M. Bishop

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

none

7. Birth date of deceased (Mo., Day, yr.)

4-6-1868

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

77

6

15

- hrs.

- min.

9. Birthplace

mons. Missouri

(Town, county, and state)

10. Usual occupation

Trained Nurse

11. Industry or business

FATHER
MOTHER

12. Name

Benjamin C. Bishop

13. Birthplace

Smithsburg Md

14. Maiden name

Marion Drane

15. Birthplace

Prince George Co Md

16. Informant

Miss Lucie Bishop

Address

Smithsburg Md

17.

(Burial, cremation, or removal, where?)

Date thereof

2 23 1946
(month) (day) (year)

Cemetery or crematory

Smithsburg

Location

Smithsburg Md

18. Funeral director

L. B. Hoover

Address

Smithsburg Md

19.

Feb 22 1946
(Date rec'd by registrar)G. W. Ferguson
Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1946 at 7 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to Feb 21 1946
 and that I last saw him alive on Feb 21 1946

Immediate cause of death

Cerebral Hemorrhage

Due to

Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. W. Ferguson
Date signed 2/22/46

RECEIVED

MAR 5 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 990

CERTIFICATE OF DEATH

Dr. Earl Young

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Weeks

Hospital, institution, or street address where death occurred:

Wash. Co. Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 620 No. Prospect St.

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Funk Blicken staff

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Lizzie M.6.(c) If alive, give age 66 Years7. Birth date of deceased (mo., day, yr.) Sept. 22 1877

8. AGE: Years Months Days If less than one day

6851

.....hrs.min.

9. Birthplace Wolfesville Fredrick Co. Md.

(Town, county, and state)

10. Usual occupation Carpenter11. Industry or business Own Busniess12. Name Simeon Blickenstaff13. Birthplace Wolfesville Md.14. Maiden name Sarah Bitts15. Birthplace Wolfesville Md.16. Informant Mrs Lizzie M. BlickenstaffAddress Hagerstown Md.17. Burial Date thereof 2.26 /46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb. 26 46 Registrar ShastH. Bowers

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 19 46 at 6:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-2-46 19 46 to 2/23/46and that I last saw him alive on 2/23/46 19 46

Immediate cause of death

DURATION

Constrictive Heart Failure

Due to

Due to

Other conditions Chronic Rheumatoid Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Earl Young

M. D. or other

Address Hagerstown Md. Date signed 2/26/46

RECEIVED
FEB 28 1946
BUREAU V. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1248

01927

CERTIFICATE OF DEATH

Reg. Diat. No. 304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? two weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County MorganCity or town St. Johns Run
(If outside city or town limits, write RURAL and give nearest town)Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Mary Agnes Bohrer

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife

Harry Bohrer7. Birth date of deceased (mo., day, yr.) Sept. 9 - 18956. (c) If alive, give age 58 years8. AGE: Years 50 Months 5 Days 7 hrs. min. 9. Birthplace Morgan Co. W. Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Hugh Crouse13. Birthplace Morgan Co. W. Va.14. Maiden name Catharine Stoller15. Birthplace Morgan Co. W. Va.16. Informant Harry BohrerAddress Berke Springs, W. Va. R.F.D. 117. Burial BuriedDate thereof Feb. 19 - 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union ChapelLocation Overton W. Va.18. Funeral director Charles R. BastAddress Hancock, Md.19. 2/16/46 19 46

(Date rec'd by registrar)

Registrar John H. Veller

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16-46 at 2 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4-5 to 2-16-46and that I last saw her alive on 2-15-46 19 46Immediate cause of death Cirrhosis of liver

DURATION

Due to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Herbert R. Tobias M.D.

M. D. or other

Address Hancock, Md. Date signed 2-16-46

RECEIVED
FEB 19 1946
BUREAU

RECEIVED
FEB 19 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01928345
Reg. Dist. No. 345

1. PLACE OF DEATH:

County Washington
 City or town Bonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred
N. Main St.
 How long in hospital or institution? 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Benevola Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Bonsboro Md. R.1
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mahlon E. Borman

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January 8, 1857
 8. AGE: Years 89 Months 1 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Benevola Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Emanuel Borman
 13. Birthplace Benevola Wash. Co. Md.
 MOTHER 14. Maiden name Sarah Eavey
 15. Birthplace Benevola Wash. Co. Md.

16. Informant Mrs. Roger Bender
 Address Bonsboro Md.

17. Burial Date thereof Feb. 16, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Falmey Cemetery
 Location near Mapleville Md.

18. Funeral director Wm. J. Basterson
 Address Bonsboro Md.

19. Feb. 16, 1946 John H. Bast
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13th 1946, at 7:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 23rd 1938 to Feb. 13th 1946

and that I last saw him alive on Jan. 7, 1945

Immediate cause of death Arterial Hemorrhage DURATION 7 years
(seen on arrival)

Due to Arterial Hypertension

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John H. Bast M. D. or other _____

Address Bonsboro Md. Date signed 2/16/46

RECEIVED

FEB 19 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

01929

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington

City or town..... Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

50 years

Hospital, institution, or street address where death occurred:

128 South Prospect Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington

City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 South Prospect Street

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Jane Wilson Byron

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Joseph C. Byron

7. Birth date of

deceased (mo., day, yr.) July 14, 1868

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

77

6

29

hrs.

min.

9. Birthplace

Union Town, Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

David Wilson

13. Birthplace

14. Maiden name

Annie Maria Zollikofer

15. Birthplace

16. Informant

David Byron

Address

Hagerstown, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2-16-46

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland

18. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19.

Feb 16 1946

(Data rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 2/13 1946 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/13 1946, to 2/13 1946
and that I last saw h. or alive on 19

Immediate cause of death

Typhoid Pneumonia
Influenza -

DURATION

10 days

Due to

Coronary Thrombosis
Occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

T. H. Swillen

Injured at work?

23. SIGNATURE

T. H. Swillen
131 W. WASHINGTON ST.

M. D. or other

Address..... Date signed 2/14/1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 19 1946

BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

01930

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown Hospital
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Wash. Gen. HospitalHow long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown Hospital
 (If outside city or town limits, write RURAL and give nearest town)

Street No. P.O. Box 3100
 (If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME

Bennie E. Cline

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Hubert Cline

7. Birth date of deceased (mo., day, yr.)

Feb. 25, 19146. (c) If alive, give age 32 1/2 years

8. AGE:

29

Years

Months

4

Days

25

If less than one day

- hrs.- min.

9. Birthplace

Smithsburg md
(Town, county and state)

10. Usual occupation

Home Keeping

11. Industry or business

Same as above

FATHER

12. Name

Samuel Webb

13. Birthplace

Near Beavers Creek

MOTHER

14. Maiden name

Laura Brown

15. Birthplace

Near Smithsburg

16. Informant

Hubert Cline

Address

Smithsburg md

17.

(Burial, cremation, or removal, which?)

Date thereof

2-26-1946
(month) (day) (year)

Cemetery or

Pleasant Valley

Location

Pleasant Valley near Smithsburg

18. Funeral director

Geo. B. Wooster

Address

Smithsburg md

19.

Feb 25 46

19.

46Blair H. Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 20 1946 to Feb 23 1946and that I last saw him alive on Feb 23 1946

Immediate cause of death

Myocardial infarction

DURATION

3 mo

Due to

Chronic endocarditis

Due to

Rheumatic heart

Other conditions

dissecting

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hagerstown

M. D.

Date signed 2/20/46

RECEIVED
FEB 27 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

01931

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington CountyCity or town Downsville Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrs.

Hospital, institution, or street address where death occurred:

Downsville Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Downsville Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. Downsville Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

John E. Cline

3.(b) Social Security Number

215-01-9862

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	---

6.(b) Name of husband or wife Minnie Cline6.(c) If alive, give age 50 years7. Birth date of deceased (mo., day, yr.) July 18 1889

8. AGE: Years <u>56</u>	Months <u>6</u>	Days <u>17</u>	It less than one dayhrs.min.
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9. Birthplace Washington County Md.
(Town, county, and state)10. Usual occupation Labor11. Industry or business Byrons Tannery Williamsport

FATHER	12. Name <u>Levi I Cline</u>
	13. Birthplace <u>Frederick Co. Md.</u>

MOTHER	14. Maiden name <u>Martha Detrow</u>
	15. Birthplace <u>Frederick Co. Md.</u>

16. Informant Mrs. Minnie Cline
Address Downsville Maryland17. Burial Date thereof Feb. 20 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenlawn CemeteryLocation Williamsport, Maryland18. Funeral director Edith V. LeafAddress Williamsport, Md.19. Feb 20 1946 Mrs E Lee McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17/46 1946 at 4 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/17/46 1946 to 2/17/46 1946 and that I last saw him alive on 2/17/46 1946Immediate cause of death Coronary Occlusion DURATION Immediate

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Young M.D. or otherAddress Williamsport, Md Date signed 2/17/46

RECEIVED

FEB 22 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

01932

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington CountyCity or town Williamsport Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 29 yrs

Hospital, institution, or street address where death occurred:

114 E. Frederick St.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 114 E. Frederick St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mr. Walter Corby

3. (b) Social Security Number

215-01-9899

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Lida Corbydeceased

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 30 1881

8. AGE: Years Months Days If less than one day

64728

hrs.

min.

9. Birthplace Williamsport, Md.
(Town, county, and state)10. Usual occupation Shipping Dept.11. Industry or business Byrons Tannery (Williamsport)12. Name John Walter Corby13. Birthplace Williamsport, Md14. Maiden name Alice Dodd15. Birthplace Williamsport, Md16. Informant John CorbyAddress 114 E. Frederick St. Williamsport17. Burial Date thereof March 2 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Md.18. Funeral director Edith V. LeafAddress #7 Church St. Williamsport, Md.19. March 2 46 Apr 6 Lee M. Corby
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 19 46 at 11:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb. 24 19 46, to Feb. 28 19 46;and that I last saw him alive on Feb. 28 19 46Immediate cause of death Cerebral occlusion

DURATION

4 daysDue to not known

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Dr. J. M. Corby M. D. or otherAddress Williamsport Md. Date signed 3/1/46

RECEIVED

MAR 5 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(Dr) Cohen

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Years
Hospital, institution, or street address where death occurred:
Hagerstown R.F.D. # 1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown R.F.D. # 1
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. # 1 Bridgeport
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME

Roy Harrison Crawford

3. (b) Social Security Number

214 09-1867

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Tressa

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) August 21 1887

8. AGE: Years 58 Months 5 Days 22 If less than one day
..... hrs. min.

9. Birthplace Hagerstown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Wood Worker

11. Industry or business Brandt Cabinet Works

12. Name John D. Crawford

13. Birthplace Maugansville Md.

14. Maiden name Anne Stine

15. Birthplace Rohersville Md.

16. Informant Earl L. Crawford

Address Hagerstown Md.

17. Burial Date thereof 2/15/ 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb 15 46 Registrar Bluff Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 13 19 46 at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1st 19 45 to Feb. 13 19 46
and that I last saw him alive on Feb. 13 1946

Immediate cause of death CARCINOMA Head of Pancreas DURATION 8 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Archie Robert Cohen M. D. Archie

Address Clear Spring Md. Date signed 2/14/46

RECEIVED

FEB 18 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 632

CERTIFICATE OF DEATH

01934

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County Hagerstown
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death: 20 hrs.
 Hospital, institution, or street address where death occurred: Washington Co. Hospital
 How long in hospital or institution: 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 151 N. Jonathan Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME Paul Elijah Davis

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Georgia E. Davis
 6. (c) If alive, give age 42 years
 7. Birth date of deceased (mo., day, yr.) August 6, 1880
 8. AGE: Years 65 Months 6 Days 14 It less than one day hrs. min.

9. Birthplace Lynchburg, Va.
 (Town, county, and state)

10. Usual occupation

11. Industry or business Restaurant

12. Name Richard E. Davis

13. Birthplace Lynchburg, Va.

14. Maiden name Kitty Elliott

15. Birthplace Lynchburg, Va.

16. Informant Mrs. Anna Davis Wade

Address 587 Jonathan St., Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 2/25/46
 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Wm. H. Downing

Address 281 Frederick St.

19. Feb 25 46 Registrar Wm. H. Downing

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 February 1946 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 10 Feb 46 to 20 Feb 46 and that I last saw him alive on 20 Feb 46

Immediate cause of death Overdose DURATION 3 days

Due to

Due to

Other conditions Central hemorrhage
Myocardial infarction, nonfatal
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Downing M.D. or other

Address 100 Professional Center Date signed 23 Feb 46

RECEIVED
FEB 27 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Dr. Ditto

01935

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cearfoss
 (If rural, give LOCATION)
 2.(a) If veteran, name war ---

3. (a) FULL NAME

Mrs. Ida Katherine Delauder

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Samuel
 6.(c) If alive, give age --- years
 7. Birth date of deceased (mo., day, yr.) August 26 1861
 8. AGE: Years 84 Months 5 Days 10 It less than one day --- hrs. --- min.
 9. Birthplace Clearspring Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business ---

FATHER
 12. Name Henry Hose
 13. Birthplace Clearspring
 MOTHER
 14. Maiden name Rhoda Ann Puterman
 15. Birthplace Wilmington Del.

16. Informant Oscar E. Delauder
 Address Hagerstown Md.

17. Burial Date thereof 2/9/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Leitersburg Cemetery
 Location Leitersburg Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Feb 9 19 46 Phast H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

2D. DATE OF DEATH February 7 1946 19 --- at 2.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 - 1945 to Feb 7 1946 and that I last saw --- alive on Feb 7 - 46 19 ---

Immediate cause of death Respiratory
 Due to ---
 Due to Respiratory
 Other conditions ---

DURATION

2 days

(Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---

Autopsy results ---
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide --- Date of ---
 Where did injury occur? --- (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) ---
 Means of injury --- Injured at work? ---

23. SIGNATURE Dr. W. D. H. G. M. D. or other ---
 Address --- Date signed ---

RECEIVED

FEB 12 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

01936

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County Hagerstown
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs
 Hospital, institution, or street address where death occurred:
315 N. Jonathan Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 315 N. Jonathan Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME John D. Douglas

3. (b) Social Security Number
232-26-7782

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Florance Douglas

6. (c) If alive, give age 44 years
 7. Birth date of deceased (mo., day, yr.) 11/27/1919

8. AGE: Years 26 Months 2 Days 7 If less than one day
hrs.min.

9. Birthplace Rocky Mount, N.C.
 (Town, county, and state)

10. Usual occupation Porter

11. Industry or business

12. Name John Douglas

13. Birthplace Charlotte, N.C.

14. Maiden name Minnie Whitehead

15. Birthplace Rocky Mount, N.C.

16. Informant Mrs. Minnie Douglas

Address 315 N. Jonathan St.

17. Burial Date thereof 2/6/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown, Md.

18. Funeral director Wm. H. Downey

Address 291 Federal St.

19. Feb 6 19 46 Wm. H. Downey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 19 46 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 19 45 to Feb 3 19 46
 and that I last saw him alive on Feb 3 19 46

Immediate cause of death Pulmonary Tuberculosis

Due to 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. H. Downey M. D. or other

Address 291 Federal St. Date signed Feb 3/46

RECEIVED

FEB 8 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
Park Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Park Road
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war

3. (a) FULL NAME

William Henery Edwards
 4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

P.M.

20. DATE OF DEATH Feb. 11 19 46 at 12:30

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 1-45 to Feb 11-46
 and that I last saw him alive on Feb 5-46 19 46

Immediate cause of death

DURATION

Ch. Myocarditis 4 yrs

Due to

Due to

Other conditions Smoking

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Ditto M. D. or otherAddress Hagerstown Md. Date signed 2/4/466.(b) Name of husband or wife Mary8.(c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) April 14 18678. AGE: Years 78 Months 11 Days 27 If less than one day hrs. min.9. Birthplace Berryville Clarke Co. Va.
(town, county, and state)10. Usual occupation Carpenter11. Industry or business Retired12. Name Benj. B. Edwards13. Birthplace Berryville Va.14. Maiden name Sarah Pier15. Birthplace Berryville, Va.16. Informant Harry E. EdwardsAddress Boonsboro R.F.D. # 217. Burial Date thereof 2/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb 13 19 46 Chas H Bowers

(Date rec'd by registrar) Registrar

RECEIVED

FEB 15 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 01938-802

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Years
 Hospital, institution, or street address where death occurred:
37 Coffman Ave
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 37 Coffman Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Virgie Elizabeth Fitz

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Elam7. Birth date of deceased (mo., day, yr.) August 7 18798. AGE: Years Months Days It less than one day
66 6 2 hrs. min.9. Birthplace Detour Frederick Co. Md.
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own Home12. Name J. Thomas Kemp13. Birthplace Taneytown Md.14. Maiden name Julia Eyler15. Birthplace Detour Md.16. Informant Mrs. William L. Poffenberger
Address Titusville Pa.17. Burial Date thereof 3/12/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Green Hill cemetery
Waynesboro Pa.
Location18. Funeral director Andrew K. Coffman
Address Hagerstown Md.19. Feb 12 19 46 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1946 at 6.15 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 19 37 to Feb 9 19 46
and that I last saw him or her alive on Feb 9 19 46Immediate cause of death Cerebral Hemorrhage
Endocarditis Chronic
(Mitral & Aortic Insufficiency)
Arteriosclerosis - Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. —Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of X X XWhere did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Howard Yeager M. D. or otherAddress Hagerstown Md. Date signed Feb 11 1946

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 15 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. A.P. Stouffer 61939

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 Years
 Hospital, institution, or street address where death occurred:
1199 The Terrace
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1199 The Terrace
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Anna Doty Frazer

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife John J.
 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) May 18 1848
 8. AGE: Years 97 Months 9 Days - It less than one day - hrs. - min.

9. Birthplace Lockport Niagara County N.Y.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Joseph W. Doty

13. Birthplace Lockport N.Y.

14. Maiden name Emily Wildman

15. Birthplace Lockport N.Y.

16. Informant Mrs. John J. Porter

Address Hagerstown Md.

17. Removal Date thereof 2/20/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Mausoleum

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 20. 46 Chas H Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1946 19 - at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 19 45 to Feb 18 19 46

and that I last saw him alive on Feb 15 19 46 19 -

Immediate cause of death Coronary Arteriosclerosis DURATION

Due to

Due to

Other conditions Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A.P. Stouffer M. D. or other

Address Hagerstown Md. Date signed Feb 19 46

RECEIVED

FEB 22 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1867A

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

Washington
County.....
City or town..... **Hagerstown, Maryland**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?..... **5 weeks**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... **Maryland** County..... **Washington**
City or town..... **Hagerstown**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **408 West West Washington**
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

Lee Elmer Fridinger

3. (b) Social Security Number

None

4. Sex..... **Male** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Single**
6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... **January 23, 1876**
8. AGE: Years..... **70** Months..... **0** Days..... **12** If less than one day..... hrs. min.

9. Birthplace..... **Hagerstown, Wash. Co. Md.**
(Town, county, and state)
10. Usual occupation..... **Retired Railroadman**
11. Industry or business.....

FATHER
12. Name..... **Christian Fridinger**
13. Birthplace..... **Hagerstown, Maryland**
MOTHER
14. Maiden name..... **Eliza Ernde**
15. Birthplace..... **Hagerstown, Maryland**

16. Informant..... **Mrs. Lutie Full**
Address..... **Hagerstown, Maryland**

17. Burial..... **2-7-46**
(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)
Cemetery or crematory..... **Rose Hill Cemetery**
Location..... **Hagerstown, Maryland**

18. Funeral director..... **C. M. Suter & Sons**
Address..... **Hagerstown, Maryland**

19. **Feb. 6 1946** Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Feb. 4** 19..... **46** at **6 P** M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from **Dec 28** 19..... **43** to **Feb 4** 19..... **46**
and that I last saw him alive on **Feb. 4** 19..... **46**

Immediate cause of death..... **Pulmonary embolism (?)**
DURATION.....

Due to..... **Fracture of the neck of femur, not**
Due to..... **Accidental fall, 2000**

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... **Not done**
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... **Accident** Date of **December 28, 1945**
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... **At home**
Means of injury **Accidental fall** Injured at work?

23. SIGNATURE..... **W. L. Suter M.D.**
Address..... **Hagerstown, Md.** M. D. or other
Date signed..... **2-5-46**

RECEIVED

FEB 8 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77d)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
Life
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Rear 332 West Church Street
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rear 332 West Church Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Bernard F. Full

3. (b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... June 15, 1885
 8. AGE: Years..... 60 Months..... 9 Days..... 8 If less than one day..... hrs. min.

9. Birthplace..... Hagerstown, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

FATHER: 12. Name..... Michael Full
 13. Birthplace..... Ireland

MOTHER: 14. Maiden name..... Anna Price
 15. Birthplace..... Maryland

16. Informant..... Robert Gallagher
 Address..... Hagerstown, Maryland

17. Burial..... 3-25-46
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland

19. March 25, 46
 (Date rec'd by registrar) Registrar..... Robert H. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH..... about Feb 20 19 46 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

acute alcoholic
narco-sis

Due to.....

Due to..... Ch. alcoholic

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Robert H. Wells DEPUTY MEDICAL EXAM.
 Address..... Hagerstown, Md WASH. CO., MD.
 Date signed..... 3/25/46

RECEIVED

MAR 27 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Norment

01942

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 31 Years
 Hospital, institution, or street address where death occurred:
 1 South Cleveland Ave.
 How long in hospital or institution?..... None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1 South Cleveland Ave.
 (If rural, give LOCATION)
 2.(a) if veteran, name war..... No

3. (a) FULL NAME

Mrs. Elizabeth Scott Funk

3. (b) Social Security Number

220-05-6245

4. Sex..... Female
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Widowed

6.(b) Name of husband or wife..... Chas. B.

7. Birth date of deceased (mo., day, yr.)..... January 1, 1882
 8. AGE: Years..... 64 Months..... 0 Days..... 29 hrs..... min.

9. Birthplace..... Downsville, Washington, Co. Md.
 (Town, county, and state)

10. Usual occupation..... House Wife

11. Industry or business..... Own Home

12. Name..... William E. Eader

13. Birthplace..... Leitersburg, Maryland

14. Maiden name..... Susan Angle

15. Birthplace..... Clearspring, Maryland.

16. Informant..... C. Franklin Funk

Address..... Hagerstown, Md.

17. Burial..... Date thereof..... Feb. 16, 1946

(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown, Maryland.

18. Funeral director..... Andrew K. Coffman

Address..... Hagerstown, Md.

19. Feb. 15..... 19 46..... Registrar

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 13, 1946, at..... 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 13, 1946, to February 13, 1946, and that I last saw him on February 13, 1946.

Immediate cause of death.....

Coronary occlusion..... 15 min

Due to..... Coronary arterio sclerosis

Due to.....

Other conditions..... General arterio sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... None Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... None Injured at work?

23. SIGNATURE..... Bloument m s

Address..... Hagerstown, Md. M. D. or other

Date signed..... 2/14/46

RECEIVED
FEB 18 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

01943

264

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about 60 yrs.
 Hospital, institution, or street address where death occurred:
Hillcrest Convalescent Home
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 429 McDowell Ave.
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

John B. Geist

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ida M. Geist
 6. (c) If alive, give age 81 years
 7. Birth date of deceased (mo., day, yr.) Dec. 30, 1857
 8. AGE: Years 88 Months 1 Day 20 If less than one day
hrs. min.

9. Birthplace Lancaster, Penna.
 (Town, county, and state)
 10. Usual occupation Blacksmith
 11. Industry or business (Retired)
 12. Name Henry Geist
 13. Birthplace Lancaster Co., Pa.
 14. Maiden name Mary Line
 15. Birthplace Lancaster Co., Pa.

16. Informant Ida M. Geist
 Address 429 McDowell Ave., Hagerstown
 17. Burial Date thereof Feb. 23, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown, Md.
 18. Funeral director L. F. Reeher
 Address Funkstown, Md.

19. Feb. 22 46 Shacht Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1946, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 18 1946, to Feb. 20 1946
 and that I last saw him alive on Feb. 10 1946

Immediate cause of death Cerebral Hemorrhage DURATIONDue to Arteriosclerosis, generalised ?

Due to

Other conditions Pneumonia 24 hrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. L. Campbell M.D. M. D. or otherAddress 145 W. Washington St Date signed 2/20/46

CERTIFICATE OF DEATH

STATE OF MISSOURI

DEPARTMENT OF HEALTH

MISSOURI STATE DEPARTMENT OF HEALTH

MISSOURI STATE DEPARTMENT OF HEALTH

RECEIVED

FEB 25 1946

BUREAU OF R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Years
 Hospital, institution, or street address where death occurred:
615 Elizabeth St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 615 Elizabeth St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

William Bentley Gordon

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Harriett
 6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) October 1 1865

8. AGE: Years 80 Months 4 Days 9 If less than one day - hrs. - min.

9. Birthplace Greencastle Franklin Co. Pa.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name Alexander Gordon

13. Birthplace Greencastle Pa.

14. Maiden name Sara Smith

15. Birthplace Greencastle Pa.

16. Informant Mrs. Chas Mullenix

Address Hagerstown Md.

17. Burial Date thereof 2/12/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 12 46 Chas. H. Cowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1946 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 46 to Feb 10 46 and that I last saw him alive on Feb 6 46

Immediate cause of death

DURATION

Cancer

Due to Stomach 6 mcs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. W. Smith M. D. or other

Address Hagerstown Md. Date signed 2/12/46

RECEIVED
FEB 15 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Dr. Hornbaker

01945

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Terrace North
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War II

3. (a) FULL NAME

Donald McCulloch Harding

3. (b) Social Security Number

220-18-1305

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sarah Sleasman
 6. (c) If alive, give age 36 years
 7. Birth date of deceased (mo., day, yr.) April 22 1907
 8. AGE: Years 38 Months II Days IO If less than one day _____ hrs. _____ min.

9. Birthplace Washington D. C.
 (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Fairchild Aircraft

12. Name Dr. Harry I Harding

13. Birthplace Rochester N. Y.

14. Maiden name A. Gert rude McCulloch

15. Birthplace Baltimore Md.

16. Informant Mrs. Sarah S. Harding

Address Hagerstown Md.

17. Burial Date thereof 2/5/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smithsburg Cemetery

Location Smithsburg Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 4 19 46 Thos H Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 19 46 at 9 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-29 19 46 to 2-2 19 46

and that I last saw him alive on 2/2/46 19

Immediate cause of death acute myocardial infarction DURATION 2 hours

Due to acute coronary occlusion 5 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Antopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John W Hornbaker M.D.

Address 107 W. Washington St. Hagerstown, Md. Date signed 2/4/46

RECEIVED
FEB 6 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01946

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Saint mar.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 years
 Hospital, institution, or street address where death occurred:
Jahney Memorial Home
 How long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State W. Va. County Jefferson
 City or town Shepherdstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main and Princess st
 (If rural, give LOCATION)
 2.(a) If veteran, name war None ✓

3. (a) FULL NAME

Emma Harris

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife. Single

6. (c) If alive, give age. _____ years

7. Birth date of deceased (mo., day, yr.) June - 22 - 1854

8. AGE: Years Months Days If less than one day

91 7 14 hrs. min.

9. Birthplace Shepherdstown W. Va.
(Town, county, and state)10. Usual occupation. None

11. Industry or business

12. Name Abraham Harris13. Birthplace West Virginia14. Maiden name Sarah Edwards15. Birthplace West Virginia16. Informant Miss Fanny SchoppertAddress Baithersburg Md.17. Burial Date thereof Feb. 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Elmwood CemeteryLocation Shepherdstown W. Va.18. Funeral director Wm. S. Bart & SonsAddress Baithersburg Md.19. Feb. 8, 1946 John W. Bart
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1946, at 5:30 M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4, 1946 to Feb. 6, 1946and that I last saw her alive on Feb. 5, 1946

Immediate cause of death

Chronic Myocarditis.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. S. Bart M. D.Address Baithersburg Date signed 2/8/46

RECEIVED
FEB 11 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 540 ✓

CERTIFICATE OF DEATH

01947
302
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 303 North Locust St.
 (If rural, give LOCATION)
 2.(a) if veteran, name war.....

3. (a) FULL NAME

Richard Hamilton Henson

3. (b) Social Security Number

219-05-2102

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Married
-----------------------	----------------------------------	---

6.(b) Name of husband or wife Anna Lee Henson
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Nov. 10, 1912
 8. AGE: Years 33 Months 3 Days 18 it less than one day
 hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Employed By Charlton Bors. Transfer Co.
 11. Industry or business

FATHER	12. Name <u>Fredrick Henson</u>
	13. Birthplace <u>Washington, Co. Md.</u>
MOTHER	14. Maiden name <u>Charlotte Patterson</u>
	15. Birthplace <u>Virginia</u>

16. Informant Mrs. Anna L. Henson
 Address Hagerstown, Maryland.

17. Burial Date thereof March 2, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland.

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Maryland.

19. March 2, 1946 First H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 19 46 at 12³⁰ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 28 19 46 to Feb. 28 19 46
 and that I last saw him alive on Feb. 28 19 46

Immediate cause of death	DURATION
<u>Cancer</u>	<u>Unknown</u>
Due to <u>Cancer (Bladder?)</u>	<u>One</u>
Due to <u>right mandible</u>	<u>month</u>
Other conditions	<u>longer</u>

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.
 Autopsy results Cancer right mandible
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE B. Bowers M. D. James
Hagerstown Date signed 3/1/46

RECEIVED
MAR 5 1946
BUREAU V R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

01948

Reg. Dist. No. 304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Stella Marie Hoke

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteWidowed6. (b) Name of husband or wife Albert Hoke

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 17 18848. AGE: Years Months Days It less than one day
61 10 16 _____ hrs. _____ min.9. Birthplace Washington Co.
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

FATHER 12. Name Charles Vance13. Birthplace Washington Co.MOTHER 14. Maiden name Mary E. Vance15. Birthplace Washington Co.16. Informant John VanceAddress Hancock, Md.17. Burial Date thereof Feb. 6 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Catholic CemeteryLocation Hancock, Md.18. Funeral director Snyder-RowlandAddress Hancock19. 2/5/46 19 _____
(Date rec'd by registrar) Registrar J. H. Keller

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 19 46 at 4:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 19 45 to 2/3/46 19 _____and that I last saw him/her alive on 2/2/46 19 _____Immediate cause of death cerebral hemorrhageDue to Essential Hypertension

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. Keller M. D. or other _____Address Hancock, Md. Date signed 2/5/46

Wednesday

RECEIVED
FEB 8 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-0

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County...
 City or town...
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3.5 yrs.
 Hospital, institution, or street address where death occurred:
 135 W. Church Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town...
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 135 W. Church St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME Thomas Franklin Kapewell

3. (b) Social Security Number

4. Sex Male Color or race Negro 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) December 20, 1904

8. AGE: Years 41 Months 1 Days 16 If less than one day... hrs. ... min.

9. Birthplace Burkittsville, Md. Mont.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Lewis Kapewell

13. Birthplace Burkittsville, Md.

14. Maiden name Sarah Anne Brooks

15. Birthplace Peterboro, Md.

16. Informant Miss Clara Kapewell

Address 67 W. North Street

17. Burial Date thereof 2/8/46

(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown, Md.

18. Funeral director Wm. H. Downey

Address 291 Frederick St.

19. Feb. 8, 1946 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1946 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/5 1946, to 2/5 1946, and that I last saw him alive on 2/5 1946.

Immediate cause of death Chronic Endocarditis

✓ Epilepsy

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Victor D. Miller

DR. VICTOR D. MILLER M. D. or other

Address 324 W. Washington St. Date signed 2/7/46

RECEIVED
FEB 11 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

01950 302
★ Reg. Diat. No.

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

613 Sunset Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 613 Sunset Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Leonard E. Humelsine

3. (b) Social Security Number

717-07-9397

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Catherine K. Humelsine677. Birth date of deceased (mo., day, yr.) January 28, 18758. AGE: Years 71 Months 0 Days 5 If less than one day
.....hrs.min.9. Birthplace Chambersburg, Pa.
(Town, county, and state)10. Usual occupation R etired Engineer

11. Industry or business

12. Name Manaris Humelsine13. Birthplace Chambersburg, Pa.14. Maiden name Mary Simmers15. Birthplace Chambersburg, Pa.16. Informant Mrs. Leonard E. HumelsineAddress Hagerstown, Maryland17. Burial Date thereof 2-5-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. Feb. 4 19 46 Charles H. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1946 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7/3/40 19 to 2/2/46 19 and that I last saw h. im alive on February 2, 1946 19 Immediate cause of death Coronary occlusion DURATION 2 daysDue to Coronary sclerosis Indefinite

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. S. Humelsine M. D. or otherAddress 148 W. Washington St. Date signed 2/4/46

RECEIVED

FEB 6 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Brewer

 01951 301
 ★ Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Pinesburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 days
 Hospital, institution, or street address where death occurred:
Williamsport - Pinesburg / Road
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2336 Summit Avenue
 (If rural, give LOCATION)
None
 2.(a) if veteran, name war.....

3. (a) FULL NAME

Mrs. Anna Valerie Jones

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

 6. (b) Name of husband or wife David Henry

 6. (c) If alive, give age 58 years

 7. Birth date of deceased (mo., day, yr.) December 11 1888

 8. AGE: Years Months Days If less than one day
57 2 5 hrs. min.

 9. Birthplace Shenandoah Page Co. Va.
 (Town, county, and state)

 10. Usual occupation School Teacher

 11. Industry or business Public Schools

 12. Name Cornelius Donovan

 13. Birthplace Shenandoah Va.

 14. Maiden name Fannie Breeden

 15. Birthplace Shenandoah Va.

 16. Informant David H. Jones

 Address Hagerstown Md.

 17. Burial Date thereof 2/18/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

 Cemetery or crematory Rest Haven Cemetery
Hagerstown Md.

Location

 18. Funeral director Andrew K. Coffman

 Address Hagerstown Md.

 19. Feb 18 46 Mrs E. L. McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

 20. DATE OF DEATH February 16 1946 at 9.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 8, 1945 to Feb. 16, 1946
 and that I last saw him alive on Feb. 16, 1946

Immediate cause of death

DURATION

Coronary Thrombosis 3 mo.

 Due to Arterio Sclerosis 5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

 23. SIGNATURE David R. Brewer M.D. M. D. or other

 Address Clear Spring Md. Date signed 2/18/46

RECEIVED

FEB 22 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 948

CERTIFICATE OF DEATH

Reg. Dist. No. 01952 305

1. PLACE OF DEATH:
 County Washington
 City or town Boonsboro (San Mar)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years
 Hospital, institution, or street address where death occurred:
Jahney Memorial Home
 How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MARYLAND County Washington
 City or town Boonsboro (San Mar)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Jahney Memorial Home
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3.(a) FULL NAME Miss Ida May Klein

3.(b) Social Security Number None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 7. Birth date of deceased (mo., day, yr.) May 1, 1872

8. AGE: Years 73 Months 9 Days 25 If less than one day
hrs.min.

9. Birthplace Frederick Co. Maryland.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name E. Frederick Klein
 13. Birthplace Maryland

MOTHER 14. Maiden name MARY JACOBS
 15. Birthplace Maryland.

16. Informant Miss Anna Klein
 Address Boonsboro, Md.

17. Burial BURIAL Date thereof 2-28-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory LOCUST GROVE
 Location Woodville, Frederick Co. Md

18. Funeral director C.M. WAITZ
 Address Winfield Rd. Md.

19. Jahney 26. 19 46 John H. Carl
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 19 46 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25 19 46 to February 26 19 46
 and that I last saw him alive on February 25 19 46

Immediate cause of death

Angina Pectoris.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE G.W. Loken M.D.
 Address Boonsboro Date signed 2/26/46

RECEIVED
MAR 1 1946
BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

CERTIFICATE OF DEATH

Reg. Dist. No. 01953 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4.5 years
 Hospital, institution, or street address where death occurred:
530 N. Mulberry St.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 530 N. Mulberry St.
 (If rural, give LOCATION)
 2(a) If veteran, name war None

3. (a) FULL NAME

George Washington Kline

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Katherine Kline

7. Birth date of deceased (mo., day, yr.) May - 9 - 1846 6. (c) If alive, give age _____ years

8. AGE: Years 99 Months 9 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Brunswick Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name George Kline

13. Birthplace Wash. Co. Md.

14. Maiden name Nancy Zentmeyer

15. Birthplace Wash. Co. Md.

16. Informant Mrs. Ethel Kline

Address 530 N. Mulberry St. Hagerstown Md.

17. Burial Date thereof Feb 23 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brounsho Cemetery

Location Brounsho Md.

18. Funeral director Wm F. Best & Sons

Address Brounsho Md.

19. Feb. 22, 19 46 Best & Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Feb 19 46 at 500 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about 1932 19 46 to 21 Feb 19 46

and that I last saw him alive on 8 Feb 19 46

Immediate cause of death Arterio Sclerotic Cardio Vascular Disease DURATION 15 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Am

 Date of op. _____

Autopsy results Am

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J F Bowers M. D. or other _____

Address 230 N. Bowers Date signed 22 Feb 46

MARGIN RESERVED FOR BINDING

VS A15

9-45-75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Kline

RECEIVED

FEB 25 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 596

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:-

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Co. HospitalHow long in hospital or institution? 36

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn County FranklinCity or town Lancaster
(If outside city or town limits, write RURAL and give nearest town)Street No. 112 Salmon St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

CLARA BELL KNODE

3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married6.(b) Name of husband or wife Frank B. Knode6.(c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) Sept 16th 18838. AGE: Years Months Days If less than one day
62 4 26 hrs. min.9. Birthplace Franklin Co. Pa
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John H. Hellman13. Birthplace Franklin Co. Pa.14. Maiden name Annie E. Rhines15. Birthplace Franklin Co. Pa16. Informant Virginia KnodeAddress Greencastle, Pa.17. Burial Date thereof 2/15/46
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Greencastle Pa.18. Funeral director Mrs David MartinAddress Greencastle Pa.19. Feb 14 46 Chas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1946, at 3:55 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29th 1945 to February 3, 1946and that I last saw him alive on February 14th 1946Immediate cause of death Acute Myocarditis

DURATION

3 days

Due to

Due to

Other conditions Chr. Arthritis2 + yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. Gelland M.D.

M. D. or other

Address Greencastle, Pa. Date signed 2-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Samuel

WILLIAM L. B. B.

ASSISTANT

RECEIVED
FEB 16 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**
of deceased is shown on

2411 N. Charles St., Baltimore (6)

FILM No. I 00 FEB 26 1946

CERTIFICATE OF DEATH

Dr. Cohen
01953

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, institution, or street address where death occurred:
Washington Co. Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown R.F.D. # 2
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. # 2
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME

Mrs Virginia Handshaw Layman

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
8. (b) Name of husband or wife William Henry
8. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Jan 6 1863
8. AGE: Years 81 Months 83 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Elkton Rockingham Co. Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business own Home
12. Name No Record
13. Birthplace No Record
14. Maiden name No Record
15. Birthplace No Record

16. Informant Mrs Sadie C Stephen
Address Braddock Heights Md.
17. Burial Date thereof Feb. 16/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory McGaheysville, Cemetery.
Location Mc Gaheysville Va.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. Feb. 14 19 46 Chas. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

Noon

20. DATE OF DEATH February 12 19 46 at 12 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 19 46 to February 12 19 46
and that I last saw her alive on February 12 19 46
Immediate cause of death Uremia, acute
Diabetes Mellitus
Pneumonia, Hypostatic
Terminal
Other conditions _____
(Include pregnancy within 3 months of death)

DURATION
3 days

?

2 days

Major findings of operations None
Date of op. _____
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where)? _____
Means of injury _____ Injured at work?

23. SIGNATURE Pauli Robert Cohen M. D. Cleophring End
Address _____ Date signed 2/13/46

RECEIVED

FEB 16 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01956

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town 7400 Fortum
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. Lamir Place
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Roberta Linden Lidy

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) May 4, 18688. AGE: Years 77 Months 8 Days 27 If less than one day hrs. min.9. Birthplace Waynesboro, Pa.
(Town, county, and state)10. Usual occupation House work

11. Industry or business

12. Name H. Frank Lidy13. Birthplace Franklin Co. Pa.14. Maiden name A. Elizabeth Wickel15. Birthplace Waynesboro, Pa.16. Informant Miss Mary B. LidyAddress Washington D.C.17. Cremation Date thereof 2/4/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Washington D.C.Location Washington D.C.18. Funeral director Walter G. NealAddress 27 S. Church St. Waynesboro, Pa.19. Feb 1 19 46 Phyllis Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 19 46 at 4²⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 26 19 46 to Feb. 1 19 46and that I last saw him alive on Jan. 31 19 46Immediate cause of death Pneumonia

DURATION

24 hrs.

Due to

Due to

Other conditions Diabetesleft from (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically. ✓

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1/24/46Where did injury occur? Washington PS-lead U.S.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of Injury fall Injured at work?23. SIGNATURE Phyllis Bowers

M, D. or other

Address Washington, D.C. Date signed Feb 1/46

CERTIFICATE OF DEATH

RECEIVED

FEB 3 1948

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 01957 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
931 Maryland Ave. Hagerstown Md.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 931 Maryland Ave. Hagerstown
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Lillie Florence Rudy

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Joseph Rudy 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July, 31 - 1861
 8. AGE: Years 84 Months 6 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace near Myersville Fred. Co. Md.
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business _____

FATHER 12. Name Josiah Leatherman

13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden name Sarah Snyder

15. Birthplace Frederick Co. Md.

16. Informant Mrs. Fred Jones

Address 931 Maryland Ave. Hagerstown Md.

17. Burial Date thereof March 1, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory United Brethren Cemetery

Location Myersville Md.

18. Funeral director Wm. J. Bast & Son

Address Boonsboro Md.

19. Feb 28 46 Shelby Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 26, 1946 5:15 P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 24, 1946 to Feb 26, 1946

and that I last saw him/her alive on Feb 24, 1946

Immediate cause of death Hypostatic Pneumonia

Chronic Myocarditis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE B. B. Bowers

148 W. 1st St. Hagerstown W. J. M. D. or other

Address _____ Date signed 2/26/46

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 1/2 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 330 North Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Lushbaugh 3rd.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 28, 1945

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

326

hrs.

min.

9. Birthplace Hagerstown, Washington Co. Md.
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

MOTHER

12. Name William Lushbaugh Jr.13. Birthplace Hagerstown, Wash. Co. Md.14. Maiden name Ellen May Hill15. Birthplace Hagerstown, Wash., Co. Md.

16. Informant

Ellen May Lushbaugh

Address

Hagerstown, Maryland.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 25, 1946
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Maryland.19. Feb. 25, 1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1946 19 12:05 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21, 1946 19 Feb. 22 19 46and that I last saw him alive on February 22, 1946 19

Immediate cause of death

General Septicemia, pneumonia, acute meningitis

DURATION

2 daysDue to Bronchial pneumonia's duration, P.H. lowerCultures were negative.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results 2/22/46 Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bob Lushbaugh, M.D.

M. D. or other

Address 148 W. Washington St.,Date signed 2/25/46

RECEIVED
FEB 27 1946
BUREAU T S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 350 West Patrick Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Raymond E. Marken

3. (b) Social Security Number

214-10-2887

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mildred Catherine Marken

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

January 9, 1907

8. AGE:

Years

39

Months

1

Days

27

If less than one day

..... hrs. min.

9. Birthplace Middletown, Maryland

(Town, county, and state)

10. Usual occupation

Truck Driver

11. Industry or business

G. L. Baking Company12. Name John Marken

13. Birthplace

Frederick County, Md.

14. Maiden name

Ella Bradley15. Birthplace Middletown, Maryland16. Informant M.R. Etchison & Sons

Address

Frederick, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2-9-46

(month) (day) (year)

Cemetery or crematory Mt. Olivet CemeteryLocation Frederick, Md.18. Funeral director M.R. Etchison & Sons

Address

Frederick, Md.19. Feb. 6.

(Date rec'd by registrar)

19 46Chas. H. Rowser

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 19 46 at 6.05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

Multiple fractures of skullDue to Shock

(closed)

24 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results as above Feb. 6 - 46

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Feb. 5 '46Where did injury occur? Hagerstown Wash Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Truck struck end of bridgeMeans of injury yes

23. SIGNATURE

S. Robert Wells

WASH. CO., MD.

M. D. or MD.Address Hagerstown, Md. Date signed Feb. 6/46

RE
FEB 17 1968
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Lusby

01960

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Years
 Hospital, institution, or street address where death occurred:
345 West Side Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 345 West Side Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

Helen Jane Marrone

3. (b) Social Security Number

219-20-4938

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>	
8. (b) Name of husband or wife <u>James</u>		8. (c) If alive, give age _____ years	
7. Birth date of deceased (mo., day, yr.) <u>April 28, 1902</u>			
8. AGE: Years <u>43</u>	Months <u>9</u>	Days <u>23</u>	If less than one day _____ hrs. _____ min.
9. Birthplace <u>Union Bridge Carroll Co. Md.</u> (Town, county, and state)			
10. Usual occupation <u>Clerk</u>			
11. Industry or business <u>U.S. Post Office</u>			
12. Name <u>Albert Fowble</u>			
13. Birthplace <u>Union Bridge, Md.</u>			
14. Maiden name <u>Jane Bowersox</u>			
15. Birthplace <u>Union Bridge, Md.</u>			
16. Informant <u>Mrs Clara Selby</u> Address <u>Hagerstown, Md.</u>			
17. Burial <u>Burial</u> Date thereof <u>Feb. 23/1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Mt. View Cemetery</u> Location <u>Union Bridge, Maryland</u>			
18. Funeral director <u>Andrew K. Coffman</u> Address <u>Hagerstown Maryland.</u>			
19. <u>Feb. 22</u> 19 <u>46</u> <u>Chas. H. Bowersox</u> (Date rec'd by registrar) Registrar			

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 19 46 at 9 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 22 Jan 19 46 to 20 Feb 19 46 and that I last saw her alive on 20 Feb 19 46

Immediate cause of death Auricular Fibrillation - Myocardial Failure

DURATION unknown

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide AA Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE F. F. Lusby M. D. or other
 Address 230 N Potomac St Date signed 21 Feb 46

RECEIVED
FEB 25 1946
BUREAU 78

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

01961

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? TransientHospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Virginia County BerkleyCity or town Cherry Run
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION) ✓

2.(a) If veteran, name war _____

3. (a) FULL NAME

Edward Sherman Mason

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Pearl Butts7. Birth date of deceased (mo., day, yr.) Feb. 2, 18808. AGE: 66 Years 7 Months 7 Days If less than one day _____ hrs. _____ min.9. Birthplace Morgan County, W. Va.
(Town, county, and state)10. Usual occupation Sawyer11. Industry or business Saw Mill12. Name George Mason13. Birthplace Frederick Co., Va.14. Maiden name Nancy Hoile15. Birthplace Maryland16. Informant Mrs. Pearl MasonAddress Cherry Run, W. Va.17. Burial Feb. 12-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rosedale CemeteryLocation Martinsburg, W. Va.18. Funeral director Howard K. BrownAddress Martinsburg, W. Va.19. Feb. 10, 46 Cliff Sowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1946 12:10 at A.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

Multiple closed fracturesDue to of skull & shockClosed fracture of left humerus

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2/8/46Where did injury occur? Route 532 near road turn off

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Potomac River Bridge at Hancock, Md.Means of injury collision auto Injured at work?

WASH. CO., MD.

23. SIGNATURE S. Robert WellsAddress Hagerstown, Md. Date signed 2/9/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 12 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**
 County **Rural, Hagerstown**
 City or town **Life**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Hagerstown, Route 3
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State **Maryland** County **Washington**
 City or town **Rural, Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **Hagerstown, Route 3**
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME
Charles Henry McCall

3. (b) Social Security Number
None

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Widower**
 6. (b) Name of husband or wife **Ida Mc Call**
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) **September 19, 1874**
 8. AGE: Years **71** Months **4** Days **28** It less than one day hrs. min.

9. Birthplace **Hagerstown Wash. Co. Md.**
 (Town, county, and state)
 10. Usual occupation **Retired Plumber**
 11. Industry or business
 12. Name **William McCall**
 13. Birthplace **Hagerstown, Maryland**
 14. Maiden name **Alice Davis**
 15. Birthplace **Hagerstown, Maryland**

16. Informant **Ralph Kershner**
 Address **Hagerstown Route 3**

17. Burial Date thereof **2-19-46**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
Rose Hill Cemetery
 Cemetery or crematory
Hagerstown, Maryland
 Location

18. Funeral director **C. M. Suter & Sons**
 Address **Hagerstown, Maryland**

19. **Feb 19 46** **Bluff Bowers**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Feb 16 - 46** at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 1 - 45 to **Feb 16 - 46**

and that I last saw him alive on 19
 Immediate cause of death **2/9/46**

Other conditions

Due to **Ch. Myocarditis** **5 yrs**

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **JW Duth** M. D. or other

Address **Hagerstown Md** Date signed **2/19/46**

RECEIVED

FEB 21 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01963

Reg. Dist. No. 304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 hoursHospital, institution, or street address where death occurred:
Casa CurialesHow long in hospital or institution? Joseph C. Miller

3. (a) FULL NAME

Infant Son of Mr & Mrs Albert C Miller

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1946

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

16 hrs. 30 min.9. Birthplace Hancock Wash, Md.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Albert Charles Miller13. Birthplace Wash. Co. Md.14. Maternal name Myrtle Irene Lynch15. Birthplace Fulton Co. Pa.16. Informant Albert MillerAddress Hancock R. 71017. Burial Date thereof Feb. 9 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Peter's CatholicLocation Hancock Md.18. Funeral director Snyder - RowlandAddress Hancock Md.19. 2/9/46 19 John Miller
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (g) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 8, 1946, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-7 19 46, to 2-8 19 46and that I last saw him/her alive on 2-7 19 46Immediate cause of death Asphyxia

DURATION

Due to Premature birthDue to Fall of mother

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

23. SIGNATURE Herbert R. Thomas M.D.Address Hancock Md. Date signed 2-8-46Address Hancock Md. Date signed 2-8-46

MASSACHUSETTS STATE DEPARTMENT OF CORRECTIONS

RECEIVED TO WARDEN

RECEIVED

FEB 12 1946

BUREAU OF PRISONS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

CERTIFICATE OF DEATH

 01964
 302
 Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 38 yearsHospital, institution, or street address where death occurred:
Stickells Mill- W. Balto. St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 350 West Side Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clarence C. Monninger3. (b) Social Security Number
220-18-0144

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Cathaline Monninger7. Birth date of deceased (mo., day, yr.) Feb. 22, 1908

6. (c) If alive, give age years

8. AGE: Years 37 Months 11 Days 13 If less than one day
hrs. min.9. Birthplace Hagerstown- Wash.- Md.
(Town, county, and state)10. Usual occupation Emp. Stickell Mill11. Industry or business Hagerstown, Wash. Co. Md.12. Name John Monninger13. Birthplace Hagerstown, Md.14. Maiden name Mary Rager15. Birthplace Hagerstown, Md.16. Informant Mrs. Cathaline MonningerAddress 350 West Side Ave- Hagerstown,17. Burial Date thereof Feb. 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Feb. 10. 19 46 Chas. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1946 8:00 A. M. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

acute coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Trapped dead at work Injured at work?23. SIGNATURE H. Robert Wells WASH. CO., MD.
M. D. or otherAddress Hagerstown, Md. Date signed 2/9/46

RECEIVED

FEB 12 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1313

CERTIFICATE OF DEATH

01965

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**
 County.....
 City or town.....**Hagerstown, Maryland**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....**50 years**
 Hospital, institution, or street address where death occurred:
Hill Crest Nursing Home
 How long in hospital or institution?.....**3 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....**Maryland** County.....**Washington**
 City or town.....**Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **626 Washington Avenue**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Lydia Shilling Moser

3. (b) Social Security Number
none

4. Sex.....**Female** 5. Color or race.....**White** 6.(a) Single, married, widowed, or divorced.....**Married**
 8. AGE: Years.....**74** Months.....**9** Days.....**29** If less than one day.....**hrs. min.**
 6.(b) Name of husband or wife.....**William E. Moser**
 6.(c) If alive, give age.....**76** years
 7. Birth date of deceased (mo., day, yr.).....**April 12, 1871**

9. Birthplace.....**Funkstown, Maryland**
 (Town, county, and state)
 10. Usual occupation.....**Housewife**
 11. Industry or business.....

12. Name.....**Frederick B. Shilling**
 13. Birthplace.....**Funkstown, Maryland**
 14. Maiden name.....**Margaret Kendle**
 15. Birthplace.....**Funkstown, Maryland**

16. Informant.....**William E. Moser**
 Address.....**Hagerstown, Maryland**
 17. **Burial** Date thereof.....**2-13-46**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....**Rose Hill Cemetery**
 Location.....**Hagerstown, Maryland**
 18. Funeral director.....**C. M. Suter & Sons**

Address.....**Hagerstown, Maryland**

19. **Feb 12** 19 **46** **Booth Howard**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**Feb 11** 19 **46** at **3:30** P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 16, 1942 19..... to **Feb. 10,** 19 **46**
 and that I last saw her alive on **February 9** 19 **46**

Immediate cause of death.....**Chronic myocarditis with congestive failure** DURATION.....**2 yrs**

Other conditions.....**Pernicious anemia** 6 yrs
Chronic nephritis 1 yr
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....**Booth Howard** M. D. or other.....
 Address.....**148 W. Washington St.,** Date signed.....**2/11/46**

RECEIVED
FEB 15 1946
BUREAU V. B.

01966

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 years
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 494 N. Potomac St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Mamie Elizabeth Moser

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife Single
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 15, 1891
 8. AGE: Years 54 Months 1 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Myersville Fred. Co. Md.
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name Edward Moser

13. Birthplace Myersville Fred. Co. Md.

14. Maiden name Susan Morgan

15. Birthplace Boonsboro Wash. Co. Md.

18. Informant Mrs. Ira Stine

Address Mapleville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 9, 1946
 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. Bast & Sons

Address Boonsboro Md.

19. Feb 9 19 46 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Feb 19 46 at 6:48 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Feb 19 46 to 5 Feb 19 46

and that I last saw h. ex. alive on 5 Feb 19 46

Immediate cause of death Pneumococic Meningitis

(Type XXIV)

DURATION

2 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. J. Lusby M. D. or other _____

Address 2301 Potomac Date signed 6 Feb 46

MARGIN RESERVED FOR BINDING

9-45-15

VS-115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Lusby

RECEIVED
FEB 12 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
& birth date of deceased is shown 2411 N. Charles St., Baltimore 832

01967

1307

Reg. Dist. No.

CERTIFICATE OF DEATH

FILM No. I 01 APR 2- 1946

1. PLACE OF DEATH:

County WashingtonCity or town Rohersville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Main St.How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rohersville
(If outside city or town limits, write RURAL and give nearest town)Street No. Main St.
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Oliver Franklin Mullendore

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Minnie M. Mullendore

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

July 23 1870 1875

8. AGE:

Years

Months

Days

If less than one day

7075611

hrs.

min.

9. Birthplace Rohersville Wash. Co. Md.
(Town, county, and state)10. Usual occupation Retired Employee11. Industry or business State Road Commission12. Name Scott Mullendore13. Birthplace Wash. Co. Md.14. Maiden name Florence Horner15. Birthplace Wash. Co. Md.16. Informant Harry H. MorrisAddress Rohersville Md.17. Burial Date thereof Feb. 7, 1946
(Burial, cremation, or removal Which) (month) (day) (year)Cemetery or crematory Rohersville CemeteryLocation Rohersville Md.18. Funeral director Wm. J. Bast & SonsAddress Boonsboro Md.19. Feb. 6 19 46 Mrs. Katherine Stager
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 46 at 11:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1 19 46 to Feb. 4 19 46and that I last saw him alive on Feb. 3, 1946 19 46

Immediate cause of death

Cerebral Thrombosis

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Bast M.D. M. D. or otherAddress Boonsboro Md. Date signed 2/5/46

RECEIVED
FEB 12 1946
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

01968

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
1012 S. Potomac St.
How long in hospital or institution? 20 years at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1012 S. Potomac St.
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME

Mary Ann Newcomer

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife Single
7. Birth date of deceased (mo., day, yr.) September 2 - 1893
8. AGE: Years 52 Months 5 Days 6 If less than one day hrs. min.

9. Birthplace Beaver Creek Wash. Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Frederick W. Newcomer

13. Birthplace Leaf River Illinois

14. Maiden name Arabella Fink

15. Birthplace Beaver Creek Wash. Co. Md.

16. Informant Mrs. Stuart Murdoch

Address 1012 S. Potomac St. Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 11, 1946
(month) (day) (year)

Cemetery or crematory Church of the Brethren Cemetery

Location Beaver Creek Md.

18. Funeral director W. J. Bart & Sons

Address Brownsville Md.

19. Feb. 9 19 46 Bea H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1946 at 10:55 P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1938 to Feb. 8, 1946

and that I last saw him alive on February 8, 1946

Immediate cause of death Pulmonary tuberculosis

Due to None

Due to None

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations No operations

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE La Bue M. D. or other

Address Hagerstown Md. Date signed 2/9/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 12 1946

BUREAU V E

20

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-7)

CERTIFICATE OF DEATH

Reg. Dist. No. 003

01969

303

1. PLACE OF DEATH: County..... <u>Washington</u> City or town..... <u>Clearspring, Rural</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>20 Years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Washington</u> City or town..... <u>Clearspring, Rural</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Julia Mae Palmer</u>				3. (b) Social Security Number <u>NONE</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife..... <u>Albert Palmer</u>				B. (c) If alive, give age <u>59</u> years			
7. Birth date of deceased (mo., day, yr.) <u>July 25 1891</u>							
8. AGE: Years <u>54</u>		Months <u>6</u>		Days <u>8</u>		If less than one dayhrs.min.	
9. Birthplace..... <u>Washington Co.</u> (Town, county, and state)							
10. Usual occupation..... <u>Home Duties</u>							
11. Industry or business							
FATHER		12. Name..... <u>Nelson Marsh</u>					
		13. Birthplace..... <u>Washington Co.</u>					
MOTHER		14. Maiden name..... <u>Della Shank</u>					
		15. Birthplace..... <u>Washington Co.</u>					
16. Informant..... <u>Albert Palmer</u> Address..... <u>Clearspring, Md. Rural</u>							
17. <u>Burial</u> (Burial, cremation, or removal. Which?) Date thereof..... <u>Feb. 6 1946</u> (month) (day) (year) Cemetery or crematory..... <u>St. Pauls Cemetery</u> Location..... <u>Near Clearspring</u>							
18. Funeral director..... <u>Snyder- Rowland</u> Address..... <u>Clearspring, Md.</u>							
19. <u>Feb 5</u> 19 <u>46</u> <u>Joseph W. Murray</u> (Date rec'd by registrar) Registrar							
MEDICAL CERTIFICATION 20. DATE OF DEATH..... <u>Feb. 3, 1946</u> at <u>5 P.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Sudden death</u> to <u>Feb 3, 1946</u> and that I last saw him.....alive on.....19..... Immediate cause of death..... <u>Acute Myocarditis</u> <u>Died in sleep.</u> Due to..... <u>Authorized to sign</u> <u>certificate by</u> <u>Dr. Sam'l Welles - State Exam</u> Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations.....Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide.....Date of..... Where did injury occur?.....(City or town).....(County).....(State)..... Injured at home, farm, industry, public place (where?)..... Means of injury.....Injured at work?..... 23. SIGNATURE..... <u>David P. Brewer M.D.</u> <u>Clear Spring Md</u> M. D. or other..... Address.....Date signed..... <u>2/4/46</u>							

RECEIVED
FEB 6 1946
RPT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. (11580)

288

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 8 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 901 Main Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

James Roger Pentz

3. (b) Social Security Number

217-09-9771

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife —6. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) December 12 1912

8. AGE: Years 33 Months 2 Days 7 If less than one day — hrs. — min.

9. Birthplace Hagerstown Wash. Co. Md.
(Town, county, and state)10. Usual occupation Brakeman11. Industry or business W.M.R.R.12. Name John Samuel Pentz13. Birthplace Edinburg Va.14. Maiden name Elsie Mulligan15. Birthplace Germantown Md.16. Informant Arthur PentzAddress Hagerstown Md.17. Burial Burial Date thereof 2/22/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb 20 19 46 to M. H. Boward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1946 at 1.05 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw h. alive on 19

Immediate cause of death

hemorrhage into lungs
laceration of mesentery
and small bowel, thrombosis
of mesenteric vein

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Feb/18/46

Date of op.

Autopsy results as above 2/19/46

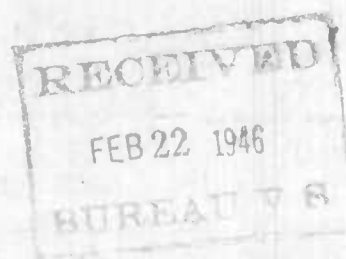
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Feb/18/46Where did injury occur? Hagerstown Wash. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) W.M.R.R.Means of injury crushed between trains yes

DEPUTY MEDICAL EXAM.

23. SIGNATURE Dr. Robert Wells WASH. CO., MD.M. D. 2/22/46Address Hagerstown Md. Date signed 2/22/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

CERTIFICATE OF DEATH

FILM No. I O 1 APR 1 - 1946

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Wagonsboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hour
Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. S. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME

Gladys Virginia Phillips

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Wilbur P. Phillips
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) January - 20 - 1920
8. AGE: Years 26 Months 1 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Locust Grove Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name William C. Ruder

13. Birthplace Locust Grove Wash. Co. Md.

14. Maiden name Iola Paffenbarger

15. Birthplace Near Rockersville Wash. Co. Md.

16. Informant Wilbur P. Phillips

Address Boonsboro Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 3, 1946
(month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. F. Bart & Sons

Address Boonsboro Md.

19. March 2 46 Chas. H. Sowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 19 46, at 3:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____

RECEIVED

MAR 5 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
70 Madison Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
70 Madison Avenue
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Harry F. Pickett

3. (b) Social Security Number

189-18-7036

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma V. Pickett
 6.(c) If alive, give age 49 years
 7. Birth date of deceased (mo., day, yr.) January 26, 1884
 8. AGE: Years 62 Months 0 Days 10 If less than one day
 hrs. min.

9. Birthplace Huntington, Pa.
 (Town, county, and state)
 10. Usual occupation Salesman
 11. Industry or business

FATHER	12. Name <u>Thomas F. Pickett</u>
	13. Birthplace <u>County Derry, Ireland</u>
MOTHER	14. Maiden name <u>Ellen J. --</u>
	15. Birthplace <u>County Derry, Ireland</u>

16. Informant Mrs. Harry F. Pickett
 Address Hagerstown, Maryland

17. Burial Date thereof 2-8-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Broadforing
 Location Broadforing, Md
C. M. Suter & Sons

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Feb. 7, 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/46 19 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/2/46 to 2/5/46
 and that I last saw him alive on 2/5/46
 Immediate cause of death

Cerebral Embolism
 DURATION 3 Days
 Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. F. Gunning
 M. D. or other
Willi. Augustus Date signed 2/7/46

RECEIVED

FEB 9 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01973

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington CountyCity or town Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 weeksHospital, institution, or street address where death occurred:
Washington County HospitalHow long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport, Md. RFD #1
(If outside city or town limits, write RURAL and give nearest town)Street No. RFD #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice Marie Polley

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Baby6. (b) Name of husband or wife Baby7. Birth date of deceased (mo., day, yr.) March 14 19448. AGE: Years Months Days If less than one day
1 11 0 hrs. min.9. Birthplace Washington County Hospital
Hagerstown Md.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name William Bond13. Birthplace Hagerstown Md14. Maiden name Lara Bell Polley15. Birthplace Williamsport, Md. RFD #116. Informant Mrs. William PolleyAddress Williamsport, Md. RFD #117. Burial Date thereof Feb. 17 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Md.18. Funeral director Edith V. LeafAddress #7 Church St. Williamsport, Md.19. Feb 16 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 19 46, at 6:30 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb 1 19 46, to Feb 14 19 46
and that I last saw him alive on Feb 13 19 46Immediate cause of death Congenital heart disease DURATION 4 mos.

Due to

Due to Not known

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Bond M. D. or otherAddress Williamsport Md. Date signed 2/16/46

RECEIVED
FEB 19 1946
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

Reg. Dist. No. 0197301

1. PLACE OF DEATH:

County Washington CountyCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 44 yrs

Hospital, institution, or street address where death occurred:

114 W. Salisbury St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 114 West Salisbury St.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

Mr. Charles C Poole

3.(b) Social Security Number

291-12-0737

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Sarah Elizabeth Poole7. Birth date of deceased (mo., day, yr.) July 15 18746.(c) If alive, give age 70 years8. AGE: Years 71 Months 7 Days 7 If less than one day
..... hrs. min.9. Birthplace Pinesburg Maryland
(Town, county, and state)10. Usual occupation Labor11. Industry or business Tannery Williamsport12. Name James Poole13. Birthplace Williamsport Md14. Maiden name Jennie Rauthrcuff15. Birthplace Williamsport, Md.16. Informant Mrs. Sarah E. PooleAddress 114 W. Salisbury St Williamsport17. Burial Date thereof Feb. 25 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Md.18. Funeral director Edith V. LeafAddress #7 Church St. Williamsport, Md.19. 2/25- 19 46 Mrs. E. Lee McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/46 19 46 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/22/46 19 46 to 2/22/46 19 46and that I last saw him alive on 2/22/46 19 46Immediate cause of death Coronary Occlusion DURATION Immediate

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. F. Young M. D. or other 2/23/46Address Williamsport, Md. Date signed 2/23/46

RECEIVED

FEB 27 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 328 08 ✓

CERTIFICATE OF DEATH

Reg. Dist. No. 019352

1. PLACE OF DEATH:

County.....Washington
 City or town.....Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....24 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?.....24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Penna. County.....Franklin
 City or town.....Greencastle, R.R.1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Viola Amanda Poper

3. (b) Social Security Number

4. Sex.....Female 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married
 6.(b) Name of husband or wife.....Charles A. Poper
 6.(c) If alive, give age.....57 years
 7. Birth date of deceased (mo., day, yr.).....November 27, 1887
 8. AGE: Years.....58 Months.....2 Days.....10 If less than one day..... hrs. min.

9. Birthplace.....Antrim Township, Penna.
 (Town, county, and state)
 10. Usual occupation.....Housewife
 11. Industry or business.....

MOTHER FATHER
 12. Name.....John B. Statler
 13. Birthplace.....Antrim Township, Pa.
 14. Maiden name.....Mary Coldsmith
 15. Birthplace.....Antrim Township, Pa.

16. Informant.....Charles A. Poper
 Address.....Greencastle, R.R.1, Pa.

17. Burial..... Date thereof.....2/10/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....Cedar Hill
 Location.....Greencastle, Pa.

18. Funeral director.....Jacob C. Peter
 Address.....Greencastle, Pa.

19. Feb. 9 46 Greath Powers
 (Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Feb. 7 1846, at 12 30 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 14 1846 to Feb. 7 1846
 and that I last saw h... alive on Feb. 7 1846

Immediate cause of death.....Carcinoma of Bladder with generalized metastasis
 DURATION.....1 yr.
 Due to.....

Due to.....
 Other conditions.....Diabetes 2 yrs
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE.....G.H. Binkley M. D. or other
 Address.....Hagerstown, Md. Date signed.....2/9/46

RECEIVED

FEB 12 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1862)

CERTIFICATE OF DEATH

Dr. Victor Miller 240

01976

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 week
 Hospital, institution, or street address where death occurred:
Washington & County Hospital
 How long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 106 Fairground Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

Samuel Clinton Powell

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Blanche
 6. (c) If alive, give age 78 years
 7. Birth date of deceased (mo., day, yr.) October 12 1869
 8. AGE: Year 76 Months 4 Day 0 If less than one day _____ hrs. _____ min.

9. Birthplace Middleburg Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Contractor
 11. Industry or business Concrete Work
 12. Name Samuel Powell
 13. Birthplace Middleburg Md.
 14. Maiden name Ananda Ridenour
 15. Birthplace Middleburg Md.
 16. Informant Mrs. Blanche Powell
 Address Hagerstown Md.

17. Burial Date thereof 2/14/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill cemetery
Hagerstown Md.
 Location
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.
 19. Feb. 13 19 46 Chas H Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1946 19 46 at 12.30 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.46 to 2/11 19 46
 and that I last saw him just alive on 2/11 19 46
 Immediate cause of death Chronic embolus DURATION
Fracture of left hip joint. 10 days
 Due to ✓
 Due to Accidental fall on icy pavement. ✓
 Other conditions ✓
 (Include pregnancy within 3 months of death)
 Major findings of operations ✓
 Date of op. _____
 Autopsy results ✓
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ✓ Accidental Date of February 12, 1946
 Where did injury occur? Hagerstown Washington Maryland
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) At home
 Means of injury Accidental fall Injured at work?
 23. SIGNATURE Victor D Miller
 DR. VICTOR D. MILLER, M. D. or other
 Address 111 W. Main St. Hagerstown Md. Date signed Feb 14

RECEIVED
FEB 15 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01937
304

1. PLACE OF DEATH:

County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 Years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Chistana Prevost

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lawrence Prevost
 7. Birth date of deceased (mo., day, yr.) January 29 1895 6. (c) If alive, give age 63 years
 8. AGE: Years 51 Months 1 Days 29 If less than one day _____ hrs. _____ min.
 9. Birthplace Washington County
 (Town, county, and state)
 10. Usual occupation Home Duties
 11. Industry or business _____

FATHER 12. Name James H. Everitt
 13. Birthplace Washington County
 14. Maiden name Dorothy E. Houck
 MOTHER 15. Birthplace Washington County

16. Informant Lawrence Everitt
 Address Hancock, Md.

17. Burial Date thereof Feb. 27 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory River View Cemetery

Location Hancock, Md.

18. Funeral director Snyder-Rowland

Address Hancock, Md.

19. 2/25-46 Registrar J. A. Heller
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/46 19_____, at 3:10 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____,

and that I last saw him _____ alive on _____ 19_____,

Immediate cause of death _____

Coronary Thrombosis as per clinical description by family

DURATION

5 Min.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. A. Heller M. D. or other _____

Address Hancock, Md. Date signed 2/25/46

RECEIVED

FEB 27 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

Reg. Dist. No. 01978 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:
73 Madison Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Pectonville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Myrtle C. Reed

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

David Reed

7. Birth date of deceased (mo., day, yr.)

January 21, 1872

8. (c) If alive, give age _____ years

8. AGE:

Years 74Months 0Days 11

If less than one day

_____ hrs. _____ min.

9. Birthplace Washington County, Md.
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

MOTHER FATHER

12. Name Isaac Hull
 13. Birthplace Wash. Co., Md.

14. Maiden name Susan Starliper
 15. Birthplace Wash. Co., Md.

16. Informant David Reed
 Address Pectonville, Md.

17. Burial Date thereof Feb. 3 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Park Head Cemetery

Location Rural Clear Spring, Md. Route 40

18. Funeral director Snyder-Rowland Funeral Home
 Address Clear Spring, Md.

19. Feb. 4, 1946 Beaht Bowers
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1946 7:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/15/46 to 2/1/46and that I last saw him alive on 2/1/46

Immediate cause of death

Cerebral Apoplexy

DURATION

2 Days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Beaht Bowers

M. D. or other

Address Willafoot Rd Date signed 2/3/46

RECEIVED

FEB 6 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

21

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1100

CERTIFICATE OF DEATH

01979

363

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Clear Spring Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Infant daughter of
Mr. & Mrs. William C. Rupp, Joyce Marie

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb. 10 - 1946

8. AGE:

Years

Months

Days

If less than one day

0002 hrs.

min.

9. Birthplace

Washington Co.
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

MOTHER FATHER

12. Name

William C. Rupp

13. Birthplace

Washington Co.

14. Maiden name

Pearl H. Seibert

15. Birthplace

Wash Co.

16. Informant

William C. Rupp

Address

Clear Spring Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 21 - 1946
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

near Clear Spring

18. Funeral director

Snyder - Randall

Address

Clear Spring Md.

19. Date rec'd by registrar

Feb. 21 - 46Joseph W. MurrayRegistrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Washington

City or town

Clear Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 20, 1946, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 20, 1946, to Feb 20, 1946,
and that I last saw her alive on Feb 20, 1946.

Immediate cause of death

Respiratory Paralysis
Birth

DURATION

Sudden

Due to

Birth Pressure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

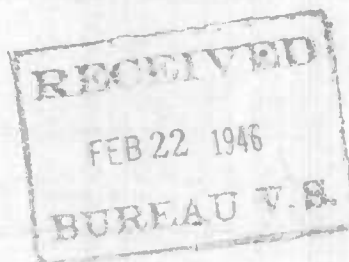
David R. Brewer M.D.

Address

Clear Spring Md.

M. D. or other

Date signed 2/21/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Kneisley

01980

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 Years
 Hospital, institution, or street address where death occurred:
136 North Potomac St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 136 No. Potomac St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

Mrs. Margaret Ann Schindel

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife

Dr. Edw. M.

7. Birth date of

deceased (mo., day, yr.)

November 23 1871

8. AGE:

Years

Months

Days

If less than one day

74326

hrs.

min.

8. Birthplace

Hagerstown Wash. co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

Daniel N. Scheller

13. Birthplace

Hagerstown Md.

MOTHER

14. Maiden name

Margaret A. Rowland

15. Birthplace

Hagerstown Md.

16. Informant

Mr. Lewis A. Emmert

Address

Huntington Pa.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... 2/22/46

(month) (day) (year)

Cemetery or crematory

Mausoleum Rose Hill Cem.

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

19

Feb. 20 46 Chas. H. Powers

Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH... February 19 1946 19... at 3.15 M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. 22, 1943 19... to Feb. 19, 1946and that I last saw him alive on February 16, 1946 19...

Immediate cause of death

Cerebral Hemorrhage

DURATION

26 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address... 148 W. Washington St.Date signed... 2/20/46

RECEIVED
FEB 22 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19/2

CERTIFICATE OF DEATH

01981502
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 1/2 Years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 1 1/2 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland..... County..... Washington
 City or town..... Smithburg..... Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

John V. Shank, Smithburg, Md.

3. (b) Social Security Number

None

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... January 25, 1861.
 8. AGE: Years..... 85 1/2 Months..... Days..... 14 If less than one day..... hrs. min.

9. Birthplace..... Smithburg, Washington, Md.
 (Town, county, and state)
 10. Usual occupation..... Retired
 11. Industry or business.....

12. Name..... Adam Shank
 13. Birthplace..... Maryland
 14. Maiden name..... Barbara Shoop
 15. Birthplace..... Maryland

16. Informant..... Ella Spigler
 Address..... Fairview, Md.

17. Burial..... Feb. 12 1946
 (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)
 Cemetery or crematory..... Cavetown Cemetery
 Location..... Cavetown, Md.

18. Funeral director..... George Hoover
 Address..... Smithburg, Maryland.

19. Feb. 11 19 46 Ghost Boxes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 9, 1946 at 10 25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
OCTOBER 8 19 44 to Feb. 9. 19 46
 and that I last saw him alive on Feb. 8 19 46

Immediate cause of death.....
CARDIOVASCULAR RENAL DISEASE ?
BENIGN PROSTATIC ?
HYPERTROPY ?
SENILITY ?
 Other conditions..... GENERAL DEBILITY ?

(Include pregnancy within 3 months of death)

Major findings of operations..... None.
 Date of op.....
 Autopsy results..... None.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of Injury..... Injured at work?

23. SIGNATURE..... Archie Robert Coler M. D. 1946
 Address..... Clear Spring, Md. Date signed 2/9/46

RECEIVED

FEB 13 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Prather

01982

228

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Smithsburg R # 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ---
 (If rural, give LOCATION)
 2.(a) If veteran, name war ---

3. (a) FULL NAME

Mrs. Minnie Myrtle Weaver Shank

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Daniel C.
 6. (c) If alive, give age 66 years
 7. Birth date of deceased (mo., day, yr.) December 1 1880
 8. AGE: Years 65 Months 2 Days 7 It less than one day hrs. min.

9. Birthplace Clearspring Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Allan Weaver
 13. Birthplace Clearspring Md.
 14. Maiden name Rebecca Repp
 15. Birthplace Clearspring Md.

16. Informant Daniel C. Shank
 Address Smithsburg Md. R # 2
 17. Burial 3/10/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Millers Mennonite Cemetery
 Location near Leitersburg Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Feb 9 46 Dr. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1946 at 10.30 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3 46 to Feb 8 46
 and that I last saw her alive on Feb 8 46

Immediate cause of death Cerebral hemorrhage DURATION 2 da.
 Due to chronic nephritis 2 yrs
 Due to ---
 Other conditions ---
 (Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---
 Autopsy results ---
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide --- Date of ---
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) ---
 Means of injury --- Injured at work? ---

23. SIGNATURE Dr. Prather M. D. or other ---
 Address Hagerstown Date signed 2/8/46

RECEIVED

FEB 12 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Zimmerman

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
City or town St. James
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, institution, or street address where death occurred:
St. James
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town St. James
(If outside city or town limits, write RURAL and give nearest town)
Street No. St. James
(If rural, give LOCATION)
2(a) If veteran, name war None

3. (a) FULL NAME

William Henry Sheeley

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary E.

6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec. 6 1872

8. AGE: Years 73 Months 2 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Beaver Creek Wash Co. Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Own Emplor

12. Name Isaiah Sheeley

13. Birthplace Westminster Md.

14. Maiden name Mary Kinsey

15. Birthplace Beaver Creek Md.

16. Informant Mrs Annie Sheeley

Address Hagerstown Md.

17. Burial Date thereof 2/26/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 26 1946 John W. Best
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 19 46 at 11 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23 19 46 to Feb. 23 19 46

and that I last saw him alive on Feb. 23 19 46

Immediate cause of death _____ DURATION _____

Coronary Occlusion 1 hour

Due to not known

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Zimmerman M. D. or other _____

Address Washington Md. Date signed 2/24/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 4 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-E

CERTIFICATE OF DEATH

Dr. Conrad

Reg. Dist. No. 305

1. PLACE OF DEATH:

County WashingtonCity or town Breathedsville Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Months

Hospital, institution, or street address where death occurred:

Md State Ref. For Males

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Calvin Simms

3. (b) Social Security Number

219 - 22 - 5852

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

December 4 1927

8. AGE:

Years

Months

Days

If less than one day

18211

hrs.

min.

9. Birthplace Brandy wine prince Georges Co Md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

Farm

FATHER

12. Name

Thomas E. Simms

13. Birthplace

Brandywine Md.

MOTHER

14. Maiden name

No Record

15. Birthplace

No Record16. Informant Md State Ref. For. Males

Address

Breathedsville Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2/16/46

(month) (day) (year)

Cemetery or crematory

Waldorf Cemetery

Location

Waldorf Maryland18. Funeral director Andrew K. Coffman

Address

Hagerstown Md.19. Feb. 16.

(Date rec'd by registrar)

19. 46John H. Back
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 19 46, at 9:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1 19 46, to Feb. 16 19 46and that I last saw him alive on Feb. 16 19 46

Immediate cause of death _____

DURATION

Pulmonary Tuberculosis2 months

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE

Robert P. Conrad MD

M. D. or other

Address Hagerstown Md Date signed 2-16-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Breathedsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? from 2/15/46
 Hospital, institution, or street address where death occurred:
Maryland State Reformatory for Males
 How long in hospital or institution? from 2/15/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 909 N. Broadway, Baltimore
 (If rural, give LOCATION)
 2(a) If veteran, name war NO RECORD ✓

3. (a) FULL NAME

JOHN L. SMITH

3. (b) Social Security Number

NONE

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) 1899 8. (c) If alive, give age _____ years

8. AGE: Years 47 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation clerk

11. Industry or business NO RECORD

12. Name NO RECORD

13. Birthplace NO RECORD

14. Maiden name NO RECORD

15. Birthplace NO RECORD

16. Informant MD. STATE REFORMATORY FOR MALES

Address BREATHEDSVILLE, MD.

17. Removal Date thereof March 1, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer Cem.

Location Baltimore, Maryland.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Maryland.

19. Mar. 1, 46 John A. Best
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 19 46, at 4 A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15, 19 46, to Feb. 28, 19 46, and that I last saw him alive on Feb. 27, 19 46.

Immediate cause of death _____ DURATION _____

Pulmonary Tuberculosis 7 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

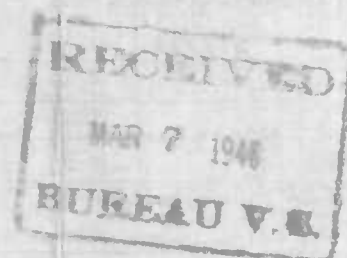
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert P. Conrad, M.D.

Address Hagerstown, Md. M. D. or other _____

Date signed 2-28-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

01986

226

Reg. Dist. No. 302

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>45 years</u> Hospital, institution, or street address where death occurred: <u>1004 S. Potomac St.</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>1004 S. Potomac St.</u> (If rural, give LOCATION) 2. (a) If veteran, name war											
3. (a) FULL NAME <u>Mary A. Smith</u>				3. (b) Social Security Number <u>213-16-1560</u>											
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>											
6. (b) Name of husband or wife <u>William A. Smith</u>				6. (c) If alive, give age years											
7. Birth date of deceased (mo., day, yr.) <u>March 11, 1876</u>				8. AGE: <table border="1"> <tr> <th>Years</th> <th>Months</th> <th>Days</th> <th>If less than one day</th> </tr> <tr> <td><u>69</u></td> <td><u>10</u></td> <td><u>26</u></td> <td>.....hrs.min.</td> </tr> </table>				Years	Months	Days	If less than one day	<u>69</u>	<u>10</u>	<u>26</u>hrs.min.
Years	Months	Days	If less than one day												
<u>69</u>	<u>10</u>	<u>26</u>hrs.min.												
9. Birthplace <u>Shippensburg Pa.</u> <u>None</u> town, county, and state				10. Usual occupation											
11. Industry or business <u>None</u>				12. Name <u>Albert R. Shugars</u>											
13. Birthplace <u>Shippensburg Pa.</u>				14. Maiden name <u>Ann A. Duke</u>											
15. Birthplace <u>Shippensburg Pa.</u>				16. Informant <u>Mrs. Thomas R. Connor</u> <u>Hagerstown Md.</u> Address											
17. Burial (Burial, cremation, or removal, which?) <u>Springhill</u> Cemetery or crematory <u>Shippensburg Pa.</u> Location <u>Shippensburg Pa.</u>				Date thereof <u>Feb. 9, 1946</u> (month) (day) (year)											
18. Funeral director <u>Scott F. Minnich & Son</u> Address <u>Hagerstown Md.</u>				19. 7-6-9 46 <u>Chas H Bowers</u> (Date rec'd by registrar) Registrar											

MEDICAL CERTIFICATION	
20. DATE OF DEATH <u>February 7 1946</u> at <u>10:45a</u>	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan/22/46</u> to <u>Feb 7 46</u> and that I last saw him alive on <u>Feb 7 46</u>
Immediate cause of death <u>Bronchopneumonia</u> <u>chr. myocarditis</u> Due to <u>bronchial asthma</u>	DURATION <u>10d</u> <u>2yrs</u> <u>2yrs</u>
Other conditions (Include pregnancy within 3 months of death) Major findings of operations <u>None</u> Autopsy results <u>None</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>None</u> Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?	
23. SIGNATURE <u>H. Robert Wells M.D.</u> <u>Hagerstown Md.</u> Date signed <u>2/5/46</u>	

RECEIVED
FEB 12 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Dr. Kinesley

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Years
 Hospital, institution, or street address where death occurred:
1910 Virginia Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1910 Virginia Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Miss Fannie Virginia Snyder

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) January 27 1871

8. AGE: Years 75 Months 0 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Roxbury Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own Home12. Name John W. Snyder13. Birthplace Middletown Md.14. Maiden name Barbara Zentmyer15. Birthplace Hagerstown Md.16. Informant Mrs Lilia ShaferAddress Hagerstown Md.

17. Burial Date thereof 2/11/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. FEB 11 19 46 Chas H Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 19 46 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 43 to February 8 19 46
 and that I last saw h. er alive on February 7, 1946

Immediate cause of death Chronic Myocarditis with congestive failure DURATION 3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B B Kinesley M. D. or otherAddress 148 W. Washington St. Date signed 2/9/46

RECEIVED
FEB 13 1946
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Dr. Kritzer 1988 257

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 36 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 36 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R # 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cedar Lawn
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

John William Snyder

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Estella
 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) December 19 1882
 8. AGE: Years 63 Months 11 Days 29 If less than one day - hrs. - min.

9. Birthplace Downsville Wash. co. Md.
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Retired
 12. Name John Snyder
 13. Birthplace Downsville Md.
 14. Maiden name Martha Graves
 15. Birthplace Downsville Md.

16. Informant Lloyd M. Snyder
 Address Hagerstown Md.
 17. Burial 2/21/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Broadfording Cemetery
 Location Broadfording Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.
 19. Feb. 20. 46 Charles Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH February 18 1946 at 8 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from AM Feb. 17 - 1946 to Feb. 18, 1946
 and that I last saw him alive on Feb. 18, 1946

Immediate cause of death Broncho-pneumonia - DURATION 2 days
 Due to -
 Due to -
 Other conditions -
 (Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -
 Autopsy results -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide - Date of -
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) -
 Means of injury - Injured at work? -
 23. SIGNATURE Charles Bowers M. D. or other -
 Address Hagerstown Md. Date signed 2/19/46

RECEIVED
FEB 22 1946
BUREAU V S.

01989

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Washington County HomeHow long in hospital or institution? TWO YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Washington County Home
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edith V. Sollenberger

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 31, 18908. AGE: Years 55 Months 6 Days 24 If less than one day
.....hrs.min.9. Birthplace Greencastle, Franklin Co., Pa.
(Town, county, and state)10. Usual occupation Clerk - Bakery

11. Industry or business

12. Name David B. Sollenberger13. Birthplace Franklin Co. Pa.14. Maiden name Elixabeth Ilesher15. Birthplace Franklin Co. Pa.16. Informant Mrs. Davis M. RuthAddress Hagerstown, Md.17. Burial Date thereof Feb. 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Feb. 26 19 46 Blasett Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1946 19 46 at 4:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb. 1st 19 46 to Feb. 24 19 46
and that I last saw her alive on Feb. 20th 19 46

Immediate cause of death

DURATION

Hemiplegia 6 mo.

Due to

Hemiplegia 24 h.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest J. Bowers
M. D. or otherAddress Hagerstown Md Date signed 2/25/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 28 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (282)

CERTIFICATE OF DEATH

01991

Reg. Dist. No. 302

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3.5 years
 Hospital, institution, or street address where death occurred:
 Washington Co. Home
 How long in hospital or institution? 5 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Washington County Home
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Anna Stewart

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... Negro 6. (a) Single, married, widowed, or divorced..... Married
 8. (b) Name of husband or wife..... Jerome Stewart
 7. Birth date of deceased (mo., day, yr.) 8-1890 8. (c) If alive, give age..... years

8. AGE: Years 55 Months 6 Days hrs. min.

9. Birthplace..... St. James, Wash., Md.
 (Town, county, and state)
 10. Usual occupation..... None

11. Industry or business

FATHER 12. Name..... Unknown Jones
 13. Birthplace.....

MOTHER 14. Maiden name..... Unknown
 15. Birthplace.....

16. Informant..... Mr. Fred Long
 Address..... Hagerstown, Md.

17. Burial..... Date thereof..... 2/21/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Md.

18. Funeral director..... Wm H Downey
 Address..... 291 Frederick St.

19. Feb. 21 1946 B. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 19th 1946 at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13th 1946 to Feb. 19 1946

and that I last saw h. or alive on Feb. 16th 1946

Immediate cause of death..... DURATION

Due to..... Hemiplegia right 6 days

Due to..... Hemiplegia left 4 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Ernest F. Pooler, M.D.
 M. D. or other

Address..... Hagerstown, Md. Date signed..... 2/20/46

RECEIVED

FEB 23 1944

BUREAU V.S.

CHANGE OF AGE: Letter
from Dr. Wells filmed 3-14-46
GLOI-LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
City or town..... Rural, Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
Hagerstown Route 2
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
City or town..... Leitersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

Clinton Edgar Stouffer

3.(b) Social Security Number

216-14-6634

4. Sex..... Male
5. Color or race..... White
6.(a) Single, married, widowed, or divorced..... Widower
6.(b) Name of husband or wife..... Florence Stouffer
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... August 10, 1882 20 1883
8. AGE: Years..... 62 Months..... 6 Days..... 5 If less than one day..... hrs. min.

9. Birthplace..... Bridgeport, Maryland
(Town, county, and state)
10. Usual occupation..... Supervisor
11. Industry or business..... Fairchild Aircraft
12. Name..... Benjamin F. Stouffer
13. Birthplace..... Bridgeport, Maryland
14. Maiden name..... Katherine Baker
15. Birthplace..... Bridgeport, Maryland
16. Informant..... Mrs. Gertrude Gossard
Address..... Leitersburg, Maryland

17. Burial..... Date thereof..... 2-20-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Rest Haven Cemetery
Location..... Hagerstown, Maryland
18. Funeral director..... C. M. Suter & Sons
Address..... Hagerstown, Maryland

19. Feb 19 46
(Date rec'd by registrar) 19 46
Registrar.....

MEDICAL CERTIFICATION

10P

20. DATE OF DEATH..... Feb/16 1946 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....
and that I last saw h..... alive on..... 19.....

Immediate cause of death.....
acute cerebral hemorrhage
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results..... no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:
Accident, suicide, or homicide..... no Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?.....

23. SIGNATURE.....
Address.....
DEPUTY MEDICAL EXA.....
WASH. CO., MD.
M. D. or.....
Date signed..... Feb. 17/46

MARGIN RESERVED FOR BINDING

9.45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 21 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

CERTIFICATE OF DEATH

01992
302
Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

124 High Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 124 High Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Roy Cleveland Swartz

3. (b) Social Security Number

578-16-8642

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

B. (b) Name of husband or wife

Lillian Swartz

7. Birth date of

deceased (mo., day, yr.)

October 25, 1888

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

57318

hrs.

min.

9. Birthplace

Hagerstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

FATHER
MOTHER12. Name Henry C. Swartz13. Birthplace White Sulphur Springs, Va.14. Maiden name Hannah Dunn15. Birthplace White Sulphur, Springs, Va.16. Informant Mrs. Frances McNameeAddress Hagerstown, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2-16-46

(month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland

18. Funeral director

C. M. Suter & SonsAddress Hagerstown, Maryland19. Feb-15 19 46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 1219 46

at

9:15

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 519 46to Feb 1219 46

and that I last saw him alive on

Feb 1219 46

Immediate cause of death

Ch. Myocarditis
Ch. Suppurative Nephritis

DURATION

2 yrs
2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

0

Date of op.

Autopsy results

0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert P. Conrad, M.D.

M. D. or other

Address

Hagerstown, Md

Date signed

2-14-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**

A year of birth of deceased is shown on

2411 N. Charles St., Baltimore 932

FILM No. I O 1 APR 10 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Now long in above place of death? Life
Hospital, institution, or street address where death occurred:
27 Madison Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 27 Madison Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clarence C. Sweigert

3.(b) Social Security Number
214-09-2314

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Viola Sweigert
7. Birth date of deceased (mo., day, yr.) July 26, 1891 1892
6.(c) If alive, give age years
8. AGE: Years 53 Months 54- Days 30 If less than one day hrs. min.

9. Birthplace Franklin Co. Pa.
(Town, county, and state)
10. Usual occupation Auto Mechanic
11. Industry or business
12. Name David A. Sweigert
13. Birthplace ----- Penna.
14. Maiden name Emma Vandrew
15. Birthplace ----- Penna.

16. Informant Mrs. Viola Sweigert
Address 27 Madison Ave.- Hagerstown, Md
17. Burial Burial Date thereof Feb. 28-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Samples Manor Cemetery
Location Sharpsburg, Md. Rural
18. Funeral director Fred W. Kraiss
Address Hagerstown, Md.

19. Feb 27 19 46 Clay H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25, 1946 19..... at 6 A. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11, 1946 to February 25, 1946
and that I last saw him alive on February 25, 1946

Immediate cause of death.....
Coronary occlusion
Due to Coronary sclerosis
Due to.....
Other conditions Chronic myocarditis
(G. K. G.)
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury..... Injured at work?
23. SIGNATURE RB Yourent MD
Hagerstown, Md. M. D. or other
Address..... Date signed 2/26/46

RECEIVED

MAR 1 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

01994

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Blairs Valley, Clearspring, Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Clearspring Rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Admiral Sword

3. (b) Social Security Number

217-10-3312

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteMarried6.(b) Name of husband or wife Jessie Sword6.(c) If alive, give age 42 years

7. Birth date of
 deceased (mo., day, yr.) Nov 2 1902

8. AGE: Years Months Days It less than one day
43 2 22hrs.min.

9. Birthplace Washington Co.
 (Town, county, and state)

10. Usual occupation Carpenter11. Industry or business J.B. Ferguson Co.

FATHER 12. Name John Sword
 13. Birthplace Washington Co.

MOTHER 14. Maiden name Bessie Bricker
 15. Birthplace Mercersburg, Pa.

16. Informant Mrs. Jessie SwordAddress Clearspring, Rural

17. Burial Date thereof Feb. 5 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Church Ofg God CemeteryLocation Blairs Valley18. Funeral director Snyder- RowlandAddress Clearspring, Md.

19. Feb 5 19 46 Joseph W. Murray
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 19 46 at 1:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7 Feb. 3rd 19 46 to 7 Feb. 3 19 46
 and that I last saw h..... alive on 7 Feb 3 19 46

Immediate cause of death Coronary Thrombosis DURATION 2 hrs.

Due to.....

Due to.....

Other condilions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David R. Brewer M.D. M. D. or other

Clear Spring Md Address Date signed 2/4/46

RECEIVED
FEB 6 1945
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

01996

Reg. Diat. No. 3022

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

19 Fairground Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 19 Fairground Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Edith V. Trovinger3.(b) Social Security Number
None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife William R. Trovinger

7. Birth date of

deceased (mo., day, yr.)

July 14, 1875

6.(c) If alive, give age years

8. AGE:

70 years6 months30 days

If less than one day

.....hrs.min.

9. Birthplace Leitersburg- Wash. Co., Md.
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

FATHER
MOTHER12. Name Solomon Hartle13. Birthplace Wash. Co., Md.14. Maiden name Mary Wagner15. Birthplace Wash. Co., Md.16. Informant William R. Trovinger
Address 19 Fairground Ave. - Hagerstown,17. Burial Date thereof Feb. 16, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Feb. 16, 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1946 19 46 at 4:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 13 1946 to Feb 13 1946
and that I last saw him alive on Feb 13 1946

Immediate Cause of Death

General Hemorrhage

DURATION

Due to

Due to

Other conditions Probable Hemorrhage

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. [Signature]Address Hagerstown, Md. Date signed Feb 13 1946

RECEIVED

FEB 19 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. 9811

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Weeks
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 179 Summit Ave.
 (If rural, give LOCATION)
 2. (a) Is veteran, name war None

3. (a) FULL NAME

George Van Tassell

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Anna Marie

7. Birth date of deceased (mo., day, yr.) March 24 1858

8. AGE: Years 87 Months 11 Days 1 If less than one day hrs. min.

9. Birthplace Brooklyn New York
 (Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business Retired

12. Name William Van Tassell

13. Birthplace New York

14. Maiden name Elizabeth Johnson

15. Birthplace New York

16. Informant Mrs Annie Welty

Address Hagerstown Md.

17. Burial Date thereof 2/27/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Hill Cemetery

Location Waynesboro Pa.

18. Funeral director Andrew K Coffman

Address Hagerstown Md.

19. Feb 26 46 Registrar Blas H. Owens
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1946 at 6:50 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Cerebral hemorrhage (traumatic) DURATION

laceration of scalp Feb. 19 - 76

Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations no Date of op. Feb/14/46

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: accident Feb/14/46

Accident, suicide, or homicide Date of Feb/14/46

Where did injury occur? Hagerstown Wash MD
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury fell down stairs injured at work? No

23. SIGNATURE S. Rhoads Wells DEPUTY MEDICAL EXAMINER

Address Hagerstown, Md. WASH. CO., MD.

Date signed 2/26/46

RECEIVED

FEB 28 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01997

Reg. Dist. No. 303

1. PLACE OF DEATH

County Washington Co.City or town Hagerstown Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Washington Co HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Fulton Co.City or town Hancock P.E.O.

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Janet Clara Weller

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 10 1945

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

034

hrs.

min.

9. Birthplace

Fulton Co. Pa.

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

12. Name

Michael Weller

13. Birthplace

Franklin Co. Pa.

MOTHER

14. Maiden name

Francis Johnson

15. Birthplace

Washington Co.

16. Informant

Michael Weller

Address

Hancock, Md. R.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 7 1946

Cemetery or crematory

Stone Ridge Cemetery

Location

Near Hancock, Md.

18. Funeral director

Snyder - Roulland

Address

Hancock, Md.

19. Date rec'd by registrar

Feb 8 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 19 46 at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 4 19 46 to Feb 6 19 46

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Bi lateral bronch pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

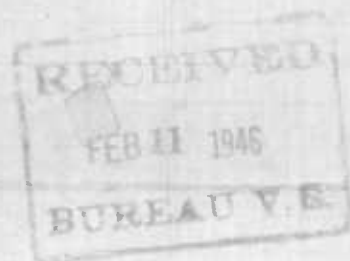
23. SIGNATURE

B. M. Shappes

M.D. or other

Address

Hancock MdDate signed 2/7/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

01998

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
534 Brown Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 534 Brown Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ruth C. Widmyer

3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 B. (b) Name of husband or wife J. Walter Widmyer.
 B. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) February 24, 1883
 8. AGE: Years 62 Months 11 Days 29 If less than one day
 hrs. min.

9. Birthplace Franklin Co., Penna.
 (Town, county, and state)
 10. Usual occupation Nurse
 11. Industry or business

FATHER 12. Name Samuel Johnston
 13. Birthplace Penna.
 MOTHER 14. Maiden name Annabelle Wills
 15. Birthplace Maryland.

16. Informant J. Walter Widmyer
 Address Hagerstown Md.

17. Burial Date thereof Feb. 23, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Hagerstown Md.
 Location

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.

19. Feb 25 19 46 Blanch Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1946 19 46 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-2-46 19 46 to 2/21/46 19 46
 and that I last saw him alive on 2/20/46 19 46

Immediate cause of death Chronic Myocardial Infarction DURATION 2 yrs.
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Blanch Bowers M. D. or other 2/23/46
 Address Hagerstown, Md. Date signed

RECEIVED
FEB 27 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *1842*

CERTIFICATE OF DEATH

Dr. Victor Miller

01999

Reg. Dist. No. *302*

1. PLACE OF DEATH:

County Washington
 City or town Maugansville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 Years
 Hospital, institution, or street address where death occurred:
Main St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Maugansville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

Mrs. Mary Louise Winter

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Jacob T.
 6. (c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) April 28 1863
 8. AGE: Years 82 Months 9 Days 20 If less than one day - hrs. - min.

9. Birthplace Hagerstown Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home

12. Name Michael Funk
 13. Birthplace Hagerstown Md.
 14. Maiden name Barbara Hershey
 15. Birthplace Hagerstown Md.

16. Informant Mrs. Mary O. Smith
 Address Maugansville Md.

17. Burial Burial Date thereof 2/21/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Ross Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Feb. 20. 46 Chas. H. Board
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH February 19 1946 at 4.30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/11 19 46, to 2/19 19 46
 and that I last saw him alive on 2/10 - 1946 19 46

Immediate cause of death Chronic Endocarditis
" Nephritis
arterio-sclerosis
 Due to arterio-sclerosis
 Due to arterio-sclerosis
 Other conditions arterio-sclerosis
 (Include pregnancy within 3 months of death)

DURATION

Major findings of operations ✓
 Date of op. 2/19/46

Autopsy results ✓
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ✓ Date of 2/19/46
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Victor Miller M. D. Chas. H. Board
 Address Hagerstown Md. Date signed 2/19 1946

RECEIVED

FEB 22 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1370)

02000

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County.....
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
 Washington County Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland Washington
 State..... County.....
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 217 S. Potomac St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Jennie F. Wissinger

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Walter Wissinger
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) December 4, 1882
 8. AGE: Years 63 Months 2 Days 18 If less than one day.....hrs.min.

9. Birthplace Near Hagerstown Wash. Md.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business Registered Nurse
 12. Name David O. Smith
 13. Birthplace Frederick Md.
 14. Maiden name Georgiana Eakle
 15. Birthplace Eakle's Mill Md.

16. Informant Mr. Harry Smith
 Address Mercersburg Pa.

17. Burial Date thereof Feb. 24, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.
 18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.

19. Feb. 23, 1945
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1946 at 1:35p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/21 1946 to 2/22 1946
 and that I last saw h. or alive on 2/22 1946

Immediate cause of death 1. Chronic Endocarditis
 2. " the family
 3. Arterio-sclerosis
 Due to.....
 Other conditions.....

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations none
 Date of op.
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE North & Miller M. D. or other
 Address..... Date signed 2/22-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 26 1946

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Young

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:
574 Pen Mar Ave.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 574 Pen Mar Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME

Still Born Child of Elmer Wolfe Jr.

3. (b) Social Security Number

No

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife None
 B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February 5, 1946

8. AGE: Years 0 Months 0 Days 0 If less than one day 1 hrs. _____ min.

9. Birthplace Hagerstown, Washington, Co. Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name Elmer Wolfe Jr.

13. Birthplace Hagerstown, Maryland.

14. Maiden name Virginia Mower

15. Birthplace Mercersburg, Penna.

16. Informant Elmer Wolfe Jr.

Address Hagerstown, Maryland.

17. Burial Date thereof Feb. 8, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bellevue, Cemetery

Location Hagerstown, Maryland.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Maryland.

19. Feb 8 19 46 Phyllis Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/46 19____ at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/5/46 19____ to 2/5/46 19____
 and that I last saw him alive on 2/5/46 19____

Immediate cause of death Prematurity DURATION 2 hrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. F. Young M. D. or other _____

Address Williamsport, Md. Date signed 2/6/46

RECEIVED
FEB 11 1946
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

020032
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Hill Crest Nursing Home
How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Funkstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Albert Tice Zentmyer

3. (b) Social Security Number

None 220-18-1191

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
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6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1862
6. (c) If alive, give age _____ years

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>4</u>	<u>22</u>	_____ hrs. _____ min.

9. Birthplace Washington Co., Maryland.
(Town, county, and state)

10. Usual occupation Retired Foundry Operator

11. Industry or business

12. Name Samuel Zentmyer
13. Birthplace Penna.

14. Maiden name Lydia Hockley
15. Birthplace Penna.

16. Informant A. Russell Zentmyer
Address Funkstown, Maryland.

17. Burial Date thereof Feb. 27, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland.

18. Funeral director Fred W. Kraiss
Address Hagerstown, Maryland.

19. Feb 27 19 46 Cliff Powers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1946 at 11:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1946 to Feb 24 1946 and that I last saw him alive on Feb 24 1946

Immediate cause of death Pneumonia, bronchial
Due to Compensation in lat
Due to Fracture of pelvis sustained in a fall
Other conditions _____

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ injured at work? _____

23. SIGNATURE W. T. Layman M.D.
Address 106 Prothonotary Bldg Date signed 2/26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 T

RECEIVED

MAR 1 1946

BUREAU V E